The Secretary's Advisory Committee on Infant Mortality, US Department of Health and Human Services

Virtual Meeting

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Reported by Gary Euell

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Ex-Officio Members - continued

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C O N T E N T S

P R O C E E D I N G S

WELCOME TO SECOND DAY/VOICES FROM THE COMMUNITY

EDWARD EHLINGER: Okay. Well, good afternoon, good morning. I now know that Jeanne is not in France, good morning for folks. Welcome back to the second day. Thank you to all of the people who helped make yesterday go really well, all of the MCHB staff, the notetakers who really did a nice job of getting me information much sooner than I thought I was going to get the notes, and then certainly the people who led the breakout sessions have gotten me information. So, I stayed up late putting all of that stuff together and sent you sort of a compilation of the efforts, which will, I hope, give us enough background and foundation for our conversation today.

Just as a start, I'm always curious about why things happen when they do. You know, why did Walter Mondale choose to die yesterday at 93 -- Walter Mondale, the former vice president, senator from Minnesota, and it struck me that in

this week when we're having a whole bunch of civil unrest related to racial disparities and this week when we're having Earth Day -- celebrating Earth Day -- that Walter Mondale, who was a champion of women's rights, civil rights, and environmental justice, you know, choose to make an exit from this world and really highlighted the fact that an individual working within the system of policy-making at the state level -- he was attorney general here and at Congress both as a senator and then as vice president and then as ambassador -- you can really have an impact. You can really change things for the better, and he was engaged in a lot of civil rights legislation, authored the Fair Housing Act, you know, was involved with a lot of environmental issues. So, I thank Walter Mondale for the good role modeling he did as a public servant and I'll keep him in mind here in Minnesota, as he was a big hero here as we move forward on this day.

We're going to start out with a video from the Delaware Department of Health. Last

week, I gave a presentation to the Delaware Maternal and Infant Care Consortium -- Mother and Infant Consortium and they put together a video that I thought was really impressive, and it followed a lot about what CDC is doing with Hear Her, and I think, you know, it follows that same format. And so, I thought it would be nice to have this voice from the community from Delaware. And yes, it is specifically focused on Delaware because that's what the purpose was. But you'll see that it is relevant to all of us in all parts of our country. So, Vincent, let's show the video.

[Video playing]

EDWARD EHLINGER: When I saw that video, it just, you know, we hear about weathering and toxic stress. It just struck me that these women in Delaware and black women in Delaware and I suspect throughout the country just have to worry every day with their health care, and it must just be overwhelmingly stressful. So, I'm wondering about your take. I don't know if you've

seen this video before, but your -- your impressions of the video.

WANDA BARFIELD: Yes. I think that it's really a wonderful video and we're seeing other locations, jurisdictions, and organizations really trying to give voice to women through these messages and on the materials that we have available to Hear Her is open to the public and people can use it and tailor it into a way that they see fit. We are trying to continue sharing the message and are now exploring the opportunity to work with the National Indian Health Board so that we can broaden our messages to American Indian/Alaska Native women. So again, there is -- there is this real importance to share this message and again, seeing other groups do this is really great.

EDWARD EHLINGER: Any comments from other members of the committee?

BELINDA PETTIFORD: You know, in North Carolina, we are in the process of rolling out our own version of a CDC Hear Her Campaign and

have really listened to the individuals with lived experience that are on our Maternal Health Task Force because they have their own stories to share. One of the latest did share her story at one of our earlier SACIM meetings. And so, I think the more we will just listen, the better off we will all be, and I think we struggle with listening for some reason. But these are people's personal stories. This is their lives, and this is what they have to live with, and if we're not listening, I think our challenge is we're just adding even more stress to their lives.

And so I think, you know, as many people as possible that can be exposed from the provider's side as well as from the women's side, the CDC Hear Her Campaign or whatever version of it that communities choose to use, I think it will be a big help to all. So, I appreciate you sharing the Delaware one.

EDWARD EHLINGER: Yeah. Well, it was interesting because they have a state rep who started out, you know, who actually moderated that

and a physician who is well known in the community who also has these concerns. So, that helps to really say this is not just about those poor women. I mean, it's the strong and powerful black women who are also having it, and so it's -- I encourage folks that if you can get those voices out there, that helps to magnify the message.

BELINDA PETTIFORD: Right and we have a North Carolina representative, an African American young woman who just issued a North Carolina version of the Momnibus Act in North Carolina, so it's a bill that I reviewed two weeks ago, and, as you know, Congresswoman Alma Adams, who has fought so much for the Momnibus, deals at the national level in Congress is from North Carolina, so she has always been a strong advocate for women's health and specifically maternal health. So, we feel fortunate that we do have that level of support and the question is what do we do with it because that's the next big piece. As, you know, you can have that support, but we know we've got some legislative support at

multiple levels, so we're excited about the opportunities.

EDWARD EHLINGER: Good. Any other comments from taskforce members? I see in the chat somebody has this video public. I think the Delaware folks are going to share it. I can't speak for them, but they were -- they said, you know, get it out and they were anxious to get feedback. So, my guess is that they're going to use this as broadly as they can.

LEE WILSON: This is Lee. I have a -- I have a question, and this is just coming out of -- coming at it from an observer's standpoint. We've been having a lot of discussions internally about discussions around weathering race and all of that and concerns about how the discussion helps to promote sort of active sort of defense of you as an individual and your rights, your needs but also how having the discussion sometimes has the potential to further traumatize. And I guess the question that I'm bringing to videos like this is I watch them and I very much appreciate,

respect, and think is necessary for women to advocate for themselves and I'm wondering what the thinking is on the other side as to how we message this in a way that they should not assume that the situation is going to be stacked against them in the event that that might give them more anxiety, and I know that there are people who specialize in this sort of messaging. But can folks speak to that and help me understand that?

EDWARD EHLINGER: I will leave that to Dr. Barfield. My guess is that you guys looked at that -- those issues in putting out the Hear Her Campaign.

WANDA BARFIELD: Yes. So, there was -- there's a lot of consideration here in terms of, you know, the messaging to make sure that we're providing information but that we also aren't traumatizing people who are also trying to, of course, be incredibly respectful, and there's a variety of stories. So, for example, last week as part of Black Maternal Health Week, I interviewed Allison Felix, who is an Olympic athlete in

California and is incredible, and her -- she had a story of a pregnancy related complication but in her case, fortunately, her providers actually noted and discovered it, and so, she wanted to also share that aspect. So, you know, trying to give some balance and the fact that there are warning signs that all of us have a role to play in terms of helping to identify these warning signs, loved ones around us as well as providers that we see.

LEE WILSON: Thank you. I just -- I -- I hope that we are not creating a situation where we're sort of putting everybody on alert about many, many health care providers who are very attentive and trying very hard to do the right thing and to make women feel both empowered and the need to be well-informed, so.

EDWARD EHLINGER: I think that's a good point and I -- when I talk about public health, I always have two definitions of public health. One is public health is the constant redefinition of the unacceptable and we're really

good at that -- pointing out all of the problems that are there, the things that are unacceptable, the things that are given that should be intolerable. The other definition is public health is what we do collectively to assure the conditions in which people can be healthy, the more positive aspects. So, I think there's -- we always have to balance pointing out the problems but then also pointing out some of the solutions and how do we move forward. And so, I think in any of these campaigns, there needs -- I think there does need to be a balance. So, thank you for bringing it up, Lee.

Thoughts from anybody else? All right. Then, let's move on, and Dr. Warren, let's give a federal update, and so we're actually -- I'm labeling these things as federal updates because there are other people within the federal government that we need to hear from, and so we're kind of setting the stage for down the road being able to make sure we get the input from as many places as we can within the federal bureaucracy.

So, Dr. Warren, it's yours.

FEDERAL UPDATE

MICHAEL WARREN: Thank you. Good morning or good afternoon to the committee. Am I sharing my slides or it looks like someone is sharing them, perfect. So, I'm going to give you some high-level updates from HRSA and from the Bureau specifically. We'll go to the next slide.

I'll start with the Bureau, give you a bit of an update on where we are with strategic planning, our equity work, and COVID response activities. So, if we could go to the next slide.

We have mentioned to you all before that we are moving through our strategic planning process. We will be unveiling our strategic goals and objectives in May. The plan is to unveil them at the AMCHP meeting and so, I look forward to you all hearing those. I really appreciate the thoughtful input that has gone into those. We've had many, many listening sessions, focus groups, key informant interviews, a comprehensive environmental scan, a review of a number of

publications, both peer-reviewed publications as well as reports from national organizations, stakeholders, et cetera, that have gone into this. So, we're really pleased with where this has ended up and look forward to sharing it later this year, next month actually, and then we will work on planned implementation and evaluation moving forward after that. Next slide, please.

This just gives you a sense of some of the activities that have happened. We've ended up with, as I said, lots of stakeholder engagement, engagement of our own staff as well, public-facing request for information process looking at a number of documents that existed and we've been hearing from thousands of stakeholders and really trying to cover the spread of the MCH population so that we can make sure we have that input. So, thank you, and I look forward to sharing that moving forward. Next slide, please.

As we continue to further our commitment to advancing equity in the MCH population, we're also looking at where we've got

opportunities internally. So, for the last four months, we have had the deputy director of HRSA's Office of Civil Rights, Diversity, and Inclusion doing a detail with MCHB to really guide our equity work and to inform Bureau leadership of some opportunities. She has developed a framework, which we've shared with our team about our approach and divides it into these three buckets: our people, our organization, and our partners.

The our people piece, as it sounds, is a more internal-facing piece where we've got opportunities for continuous learning for staff where we look at ways where we can diversify our staff and create a culture of inclusion.

When it comes to organization, that really helps us think about what our policies, our structures are, how we incorporate equity, integrate equity into all of our work. And so, this is not just the work of a detailee or one person or one office within the Bureau. It really becomes the work that we all do and it becomes

integrated into everything that we do.

And then finally, our partners, and so, how do we through this work engage the field? Specifically, how do we center and amplify the experiences of women and families, particularly those of color? How do we listen to and learn from the field, including folks that we've not historically listened to and then where are there opportunities to provide leadership for the field?

So, we're excited to further integrate this framework into our work. Our strategic plan is going to have a heavy focus on equity and the expectation moving forward is that as we publish NOFOs, as we design programs, that we are incorporating an equity lens to the extent that we can. And so, we're really excited about that and moving it forward and wanted you all to be aware of that. Next slide, please.

We've also now, as with all our federal colleagues, for over a year been responding to the COVID-19 pandemic. The HRSA response has been much broader. I'm going to talk

to you specifically about what we've been doing in the Bureau. Last year, starting in the late spring/summer and continuing through much of the year, we were responding to challenges, what I consider some of the collateral complications of COVID. So, early on in the pandemic, as there was the message to stay home unless you were really, really ill, don't seek medical care, lots of people took that to heart and that included parents with young children who needed well visits and immunizations. So, over the course of the spring/summer and into the fall, we really pushed to promote well visits and immunizations, recognizing that it's more than just getting those vaccines, it's an opportunity to check in with families on what their needs are related to a variety of social determinants to connect them with community resources and to think about screening for concerning activities, things like adverse [indiscernible] experiences. So, lots of kids and families were missing out on those. And so, the Well-Child Wednesdays Campaign was an

opportunity to help promote that.

We also recognized that the way we typically fund things is often more reactive than proactive, and sometimes states and communities need to be able to build some capacity to be able to respond to needs that are emerging before they actually emerge. And so, we spent some time working with our legal counsel and grants folks to understand how we could craft a grant opportunity that would be really open-ended and we ended up with our Emerging Issues in Maternal and Child Health NOFO that was published. We were able to set aside $1.5 million through our SPRANS, our Special Projects of Regional and National Significance, to be able to support this we got a number of applications, a lot of interest in this funding opportunity and we'll be announcing the recipients of that later this year. I hope that is something -- if this bears out the way we think it's going to, I hope that's something we'd be able to support moving forward to really bolster the capacity of states and communities to be

prepared to deal with emerging issues.

And an example emerging issue is the next item, our P4 Challenge, our Program Promoting Pediatric Primary Prevention. So, we've used these prize challenge competitions in a number of ways recently, so we are finishing up four what we call grand challenges, so one on childhood obesity, one on care coordination for kids with special health care needs, one on remote pregnancy monitoring, and one on optimizing care for pregnant women and new moms with opioid use disorder. And the way these challenges work is you put out a call around a particular topic. You ask people to submit bright ideas. The goal is to get people who aren't necessarily the typical applicants to our brand opportunities. And we get a wide range of ideas and the bar for entry is very low. It's typically a 3- to 5-page application, and so much different than our normal 60- or 80-page grant application and folks submit those applications. A round of winners are picked, they get a little bit of seed money to

implement their idea or plan, they come back with results, we then pick additional winners based on that. So, based on the success of prior challenges, we launched our P4 Challenge last summer or last fall, I should say. This is to really get people thinking about how we can innovate in the space of well visits and immunizations, recognizing the decline we've seen in those in the pandemic, and we were able to set aside $1 million for the prize purse there.

On the next slide, you'll see that we got entries -- well, sorry, I got ahead of myself. So, on the challenge, I mentioned the prize purse. We got 241 submissions from across the country. We're in the process right now of selecting up to 50 phase 1 winners. They will all get $10,000 each to implement the idea they proposed. They'll have 6 months to do that and then we'll pick 20 of those to be phase 2 winners, and they'll get $25,000 each. The ask was that they partner with community based organizations, public health, immunization programs, family serving entities,

other partners that may be unique to their communities to really think about approaches to this. And so, we will look forward to announcing those winners in May.

I think the next slide shows a map, and you'll see all across the country where the submissions came from. So, all but a handful of states submitted applications, 44 states, 193 cities, and 2 applications also from Puerto Rico. So, I really appreciate the response to this and all the work that has gone into it and judging really quickly, those 241 applications and again, soon we'll be announcing those 50 winners. Next slide, please.

And we talked about that. We'll go ahead one more.

So, early on in the pandemic response when the CARES Act passed, this was one of the earlier COVID supplemental bills, there was $15 million made available to MCHB to support telehealth activities and we made four awards in the areas you see on your screen. So, maternal

health, pediatric care, state public health systems, and family engagement. I want to talk briefly about the maternal health investment. The recipient of that was the University of North Carolina at Chapel Hill. Next slide.

They have with these funds supported their Maternal Telehealth Access Project. So, the goal of this was to increase telehealth access and help build that infrastructure both on the provider end on the patient side with an overarching goal of improving access to maternity care and that was inclusive of mental healthcare specifically during the pandemic but building some foundations that could serve us well beyond that.

On the next slide, one of the first things that the grantee did was to conduct a very robust needs assessment to understand some of the barriers to implementing telehealth and to understand where there were the areas of greatest need. So, you can see on the left-hand side of the slide, a number of barriers that were identified, some of them very familiar to us with

other MCH challenges as we think about social determinants, some as it relates to telehealth, things like low digital literacy or lack of access to internet, lack of technology and knowledge. Things that we saw actually with some of our programs is we were implementing, for example, home visiting and Healthy Start transitioning over to virtual services, recognizing that in some communities, there wasn't access to reliable internet service or broadband or maybe there was, but families didn't have devices or in some cases both. So, a lot of these barriers rose to the top in this needs assessment and the folks at UNC have identified their plan of action for moving forward with a variety of partners to help address these and again, to think about how they reach populations with the greatest needs.

So, on the next slide, just a few examples of the things they are doing. Some of their funding is going to support remote pregnancy monitoring, things like home blood pressure monitoring. They are supporting technology for

both patients and providers that allow them to access telemedicine. They are supporting training for a variety of folks in the workforce specifically on how to do this work in a virtual setting, so doulas, lactation consultants, community health workers, and then they are also supporting actual direct services being done in a virtual setting.

So, we are excited to learn more about this work as it continues. The first part of this project, as I mentioned, was really focused on better understanding the need and where to go and now they are in the implementation phase. So, I appreciate the partnership with the folks at UNC. They've done great work to date, and we'll look forward to keeping you all updated as we move forward and sharing lessons learned. Next slide, please.

So, as we look ahead, thinking about where the department is focusing and thinking about where there are needs within MCH populations, I wanted to share a few of those

ideas with you. We're actually convening a meeting on Monday in partnership with ASTHO, engaging a number of state representatives, representatives from state public health agencies, for example Title V and Children and Youth with Special Health Care Needs Programs, as well as national stakeholder organizations and a number of federal partners will be coming together to really understand what has happened to date in the response and what are the lessons learned as we look ahead, particularly as it relates to the MCH population.

So, as a very concrete example, vaccines for adolescents are pretty close on the horizon. What can we learn from the adult vaccination work that has happened to date that will help inform that and make sure that we're meeting the needs of adolescents. Eventually, vaccines will be available for younger children as well. What are considerations for pregnant women as we try to continue to have that conversation and make vaccines available for pregnant women?

So, that meeting will be next Monday and will help inform our efforts as well.

But we're looking in several buckets. One, around vaccine, how do we support vaccine delivery through MCHB-funded staff? So, a lot of our staff at the state levels have been deployed to work on the public health response. That is not new. I would say it shifted over the course of the pandemic in terms of what those folks are actually doing, but a lot of MCHB-funded staff in states are actually now being deployed to work in vaccination clinics and sites.

We also have an opportunity to think about how we train MCHB-funded staff on messaging strategies for MCH population. So, again, what are some of those lessons learned from adult vaccinations that can be applied to pediatric populations, children with special health care needs, where are there remaining needs around messaging for pregnant women that we can help fill.

And then, many of our programs, Title

V and some of our community based programs, work to educate families about how they can access vaccines in their communities. So, a lot of that connection work is going on and that will continue.

With regards to testing and tracing and activities to reduce the spread, as I mentioned, our community based programs help to connect families who may need testing with where those are available in their communities, programs like home visiting and Healthy Start, clinical services that are funded through Title V, of course, promote activities that we know help reduce the spread and then states are using their funds to continue to support telehealth efforts, and I mentioned earlier the activities that we're supporting at the federal level in those four areas of maternal health, pediatric care, family engagement, and state public health systems.

And then finally, thinking about where there are needs related to surveillance and research. So, as you all know, we fund the

National Survey of Children's Health, a national survey that is representative with estimates both at the national and state levels. It is conducted annually. This used to be an every-4-year survey and now it's done once a year, and it really gives us an idea of a broad range of indicators related to child and family well-being. We are adding COVID-19 questions to that, recognizing that those don't happen immediately, but it will give us a good opportunity to do a before and after look moving forward at the response to families before and after COVID.

We also have partnered with the Census Bureau for a much more real-time data collection activity. So, starting at the beginning of April, there were questions added to the Household Pulse Survey to ask questions specifically about childcare, about access to telehealth, and about missed preventive care. Those questions will be run through the end of June, I believe, and are available much more frequently. They will be available a number of

times between April and June, and that will give us a more real-time look at what's going on. It's a much smaller sample, so you have to be mindful of the interpretations there. But it gives us at least some data around what families with children are navigating.

And then, we are continuously looking at ways that we can partner with colleagues, for example, colleagues at NICHD around how we do some long-term followup of pediatric patients with COVID-19 through the various research networks that we fund. Next slide, please.

So, a few updates from the department and HRSA level and we'll dive into those. Next slide.

So, in terms of leadership updates, since we last convened, we now have a Secretary. Xavier Becerra is our Secretary and has been here for about a month actually this week. We also have a confirmed Assistant Secretary, Dr. Rachel Levine, and a number of other nominees continue to move forward, as you all are hearing in the news.

At the HRSA level, we do not yet have an Administrator. We have our Deputy Administrator. Diana Espinosa is serving as our Acting Administrator, and we also have a new Chief of Staff, Jordan Grossman, who was appointed after the inauguration. Next slide.

HRSA is continuing to respond to new funding that was available in the American Rescue Plan, so just under $18 billion appropriated for HRSA in that plan, and you can see here a number of the activities that were funded. Some of these have been released, some of these are still in the process of being released. So, I always tell folks the most up-to-date place to go for information is either to the hrsa.gov website and look for funding opportunities or grants.gov because before those are released, we can't talk specifically about what the content of those is going to be. I will call out that for MCHB, there was $150 million added to the MIECHV, the Maternal Infant and Early Childhood Home Visiting Program and then $80 million for the Pediatric Mental

Health Care Access Program. So, we will be working to make those funding opportunities available very soon. So, stay tuned for that.

You can see throughout the rest of the agency, a huge investment in the health centers -- the community health centers but also money for workforce activities that you see listed there and then for rural health activities as well. Next slide, please.

I also wanted to make sure that you all saw the Presidential Proclamation for Black Maternal Health Week last week and social media, so I've got the links there for you in case you missed that. Similar efforts at the department level on the next slide.

The Secretary made video remarks and also, there was an announcement through the department about the extension of Medicaid benefits in Illinois being extended up to one year postpartum with full Medicaid benefits for women for the entire first year after delivery, and then also the department announced the new funding

opportunity for the RMOMS Program, the Rural Maternity and Obstetrics Management Strategies Program that will have some increased focus this round on equity and populations that have historically suffered from worse health outcomes and health disparities and other inequities. So, the link for that also is there, and I encourage you to check that out.

Also within the Bureau last week, we hosted Dr. Zea Malawa from San Francisco. She is well known to many of you on this committee, and she spent some time talking with our team understanding the historical roots of inequities and also helping us to think about racism as a root cause and how that might apply to some of our programming work moving forward. Next slide, please.

And that's it. So, thank you. Happy to answer if you've got questions.

EDWARD EHLINGER: All right. Any questions from folks?

TARA SANDER LEE: Yes, I have a

question if nobody else does.

EDWARD EHLINGER: Sure, go ahead.

TARA SANDER LEE: Okay, great. Michael, thank you so much for that presentation. First, a couple of comments and then a final questions.

So, in regard to COVID vaccines in children, I've been doing a lot of research on this, and children are in the lowest risk group for viral infection and COVID-19 disease, and there is no solid evidence right now that children transmit the virus to adults and that vaccination reduces viral transmission. So, I know that there is increased interest in including children in these clinical trials. I know Moderna and Pfizer have already begun this, but current findings suggest that vaccination may not offer much additional protection and there's no scientific evidence that supports the administration of the COVID-19 to children. So, I'm very curious as to why this is -- why this is seen as a priority right now because I am concerned from a scientific

perspective that it's not really warranted, and so, I think we just have to be ready that there are going to be several families that are not going to be interested in vaccinating their children just based on science alone. So, I'm interested in your thoughts regarding that.

MICHAEL WARREN: So, on the -- so, I think there are two things to think about with the immunizations. So, the big push we're doing at the moment is around routine immunizations. So, not COVID-19 vaccine, but we've seen a dramatic decline in the routine pediatric immunizations because kids have not been coming in for well visits. So, that's been a big priority to date for us. Our colleagues at CDC have shown there's about a million and a half fewer measles-containing doses, for example, of vaccine in terms of a deficit since the start of the pandemic. So, a major push for us right now is to get kids and families back in for those well visits so they can get caught up on those routine immunizations.

Related to that, as adolescent COVID-

19 vaccine becomes available maybe later this summer or in the fall, right now those vaccines can't be co-administered with routine immunizations, and so, the opportunity for adolescents to get the tetanus booster that they normally get, the meningitis vaccine and HPV vaccines, there's worry that if families wait until the regular back-to-school time in August to come in and COVID-19 vaccine is available and they want that, that they've missed an opportunity to get those routine immunizations. So, routine immunizations is one bucket.

The COVID vaccines are the other. And so, we are certainly watching the research that is happening and also once that is further along, my assumption is that our colleagues at CDC and the Advisory Committee on Immunization Practices will meet and make recommendations and then we will go from there.

So, at this point, we're trying to anticipate and understand what are the lessons that we've learned to date so that as the research

moves along, so as those recommendations come along, we are poised and ready to act on those. So, that's where we are with regard to the COVID-19 vaccines.

VANESSA LEE: Okay. But right now, kind of a wait and see but be ready in case the CDC recommends it. Okay, thank you.

EDWARD EHLINGER: Any other questions that folks have or comments? I'm just curious, Dr. Warren, in your strategic planning, how did SACIM fit into that strategic planning -- does it fit into that strategic plan?

MICHAEL WARREN: It does. And so, a number of folks were involved in the interviews or listening sessions. Certainly, infant mortality has -- has long been one of those sort of bellwether outcomes that the Bureau has looked at. I mean, if you think back to the founding of the Bureau in 1912, really the first thing they focused on nationally was infant mortality. And so, I think what you will see when we unveil that plan is that the main goals and the objectives

really support our work continuing in this area.

One of our challenges was, as a Bureau, we have eleven different legislative authorities, things that are as broad as Title V and MIECHV and Healthy Start and as focused and specific at autism and sickle cell. And so, we had to fit all of those things in one strategic plan, and so it is necessarily broad. But I think the folks on this committee will be pleased with where we landed, particularly with the emphasis on equity but also on a number of the other items that you all had been talking about recently. So, I won't spoil the surprise, but we will be happy to share that very soon.

EDWARD EHLINGER: Good, thanks. One other question I have with the American Rescue Plan, with the dollars that are coming to HRSA, you'll see in our recommendations that we drafted over the last day and we'll be discussing, some of it is to say can we -- can some of those dollars actually be encouraged to focus on maternal and child health issues at the, you know, community

health center level and some of the other places. Are you doing some internal sort of advocacy for -- - in HRSA to focus some of those whatever the $18 billion to have a more MCH focus?

MICHAEL WARREN: So, we always are. I would say we take -- always take the opportunity anytime there's funding to think where there is an MCH lens that can be applied. One thing I would say is as funding becomes available to states, one of the things that I'm recognizing is that it's coming from different places within the federal government. So, states are giving funding for similar topics but from different parts of HHS or even different departments all together. And so, I think there is going to be an opportunity for us to hear from the states about where some of those overlaps are, if you will. It's not duplication of funding, but it's related funding and is there guidance that they need from us on how to connect those streams.

So, for example, there may be funds going around school health through -- through HHS

that end up going to state health agencies but the Department of Education may also have some going to state education agencies and folks in those agencies at the state level don't always talk to each other about their incoming funding streams and where there are opportunities to connect, even though they've really got shared goals. And so, I think if you all see those kinds of examples where on the ground, there are related funding streams and folks aren't making the connections and it would benefit, for example, from us giving people examples of how they can work together across agencies, we'd be happy to do that. We're trying to think proactively where those might be, but inevitably some of those are going to happen, and if folks feel like they need support from the federal partners, we are happy to engage other folks within HHS or folks across the scope of federal government to think about that.

EDWARD EHLINGER: Yeah. And in some of my conversations with Title V directors, they say well, we're losing staff because they're going

into COVID activities, and I say well, that's an opportunity actually because you can bring an MCH lens to some of those other things and actually use it to recruit more people working on COVID to be MCH advocates as well.

MICHAEL WARREN: Absolutely.

EDWARD EHLINGER: I see Tara has her hand up and Dr. Barfield has her hand up.

TARA SANDER LEE: Nope, that was just from before. Sorry about that, Ed.

EDWARD EHLINGER: Okay. And I know Dr. Barfield has some -- you're going to have a little presentation -- short presentation also. So, if you have a question and then we can get to your --

WANDA BARFIELD: Yeah, and maybe loading the slides while the questions. So, just to add to what Dr. Warren was saying, I think there is an opportunity also for MCH leadership to think more broadly, particularly around areas of health equity and social determinants of health and there is more funding that's coming out in

those areas. We just need to think about how the MCH population should be included. I mean, if we think about, you know, our discussion earlier and the implications that women are having, for example, with regard to maternal health, it isn't just about maternal-specific issues. These are broader social determinants and to the degree that we can make sure that outcomes for mothers and infants are measured in these broader legislation, I think we'll all benefit.

EDWARD EHLINGER: Good. Now, tell us about the PRAMS changes.

WANDA BARFIELD: Yes. So, I'm really excited, everyone, to talk about the PRAMS Survey Questionnaire Revision, and I just wanted to one, inform the committee on opportunities to inform us and also to help us understand more about evolving issues in maternal and infant health that we should think about and incorporate into the survey. Next slide, please.

So, just a quick review for those of you who aren't aware, PRAMS is a population-based

system that asks maternal behaviors and experiences around the time of pregnancy. It's a postpartum survey done about two to six months after delivery, and it supplements information on the birth certificate because it's linked and it has an opportunity to approximate state and near national estimates, and currently we have 50 sites and in the next funding cycle, we will also have 50 sites and there is more information on the website as listed here below. Next slide.

So, we've gone through several phases since the survey began in 1987 and we're now on phase 9, and that's due to launch in 2023. But the process involves comprehensive inventory of the current questions as well as the opportunity to consider new questions and topic areas. Next slide.

So, this is just a summary of what we have in terms of the established topics. So, there's a whole array to include preconception health, unintended pregnancy, prenatal care, health insurance, tobacco and cigarette use,

physical abuse, mental health, breastfeeding, and infant sleep environment. We've had an array of new and emerging topics since the last questionnaire revision. So, e-cigarettes, Hookah use, marijuana and drug use, prescription opioids, and, of course, the recent pandemics to include Zika and COVID as well as vaccination questions. We also have worked with NICHD to ask questions on disability in pregnancy and we're in the process of working with the Behavioral Risk Factor Surveillance System to ask questions around social determinants of health, and that's in process now. Next slide.

So, going onto the revision, next slide, the question that we would -- so, we are planning to update the survey content and make sure that we have relevance and questions in this current environment as well as other emerging priorities in maternal and child health. We'll also be capturing priority topics across CDC, other partners and their stakeholders, and we would also like the opportunity to make sure that

we align with national performance measures including Healthy People 2030, Title V programs, and other programmatic work. Next slide.

So, we will be following up with the committee in June to review the relevant topic areas and to discuss a few of the key questions as well as any suggestions for further discussion. Next slide.

So, that's it. And again, just an opportunity for the committee to be involved in this early on. So, that's why I wanted to share this information so that there really is this opportunity and, as we know, with data modernization, we're also excited about the opportunity to see additional data linkages so that we can again better understand social determinants of health and the context of the survey.

EDWARD EHLINGER: All right. Thank you for that update. I'm just curious, with the CDC's statement last week that racism is a huge public health issue, does PRAMS at all get at the

racism issue in the questions that it asks?

WANDA BARFIELD: Yes. That is a great question. So, back probably around the 2000s -- early 2000s, Dr. Kamara Jones worked on some work with BRFSS to do the Reactions to Racism module, and that was a series of questions that had asked respondents about their experiences on racism. The PRAMS Survey also incorporated some of those questions but individual states decided rather than doing it as a module or component, they might pick one or two.

One of the things that we're going to be thinking about and discussing is one, should that be a core question or should that be a standard question. So, we have three phases of questions. A core question is a question that's asked for every woman on the survey. A standard is that that is selected by the state and then there are state-based questions. So, that will be part of the discussion. But the Reactions to Racism module was used by PRAMS in some states.

EDWARD EHLINGER: Excellent. Other

questions that people have or comments?

STEVEN CALVIN: Hi. Steve Calvin here.

WANDA BARFIELD: Hi, Steve.

STEVEN CALVIN: Yeah. I wanted to -- thanks for your work and thanks for the presentation. I have a question. Does PRAMS include previous pregnancy history, like whether it's, you know, first-time pregnancy, multiple or previous pregnancies and outcomes? Does it include that or is that in the birth certificate data?

WANDA BARFIELD: So, it's somewhat limited, and this is where there would be an opportunity for data linkage. So, it does ask prior preterm birth, and that's information that's linked from the birth certificate and it -- and it may, of course, talk about c-section. But it's very limited in terms of the amount that's asked with respect to a previous pregnancy in part due to issues of recall as well as the length of the survey overall.

STEVEN CALVIN: Okay.

WANDA BARFIELD: It's about 85 questions on the survey.

STEVEN CALVIN: Great, thanks.

EDWARD EHLINGER: Any other questions or comments either for Dr. Barfield or for Dr. Warren?

BELINDA PETTIFORD: Dr. Barfield, where is PRAMS at with changing the format? I know, it seems like I remember there were going to be some pilots so that I know many of us struggle with trying to get paper versions and for people to respond to phone calls. I mean, I don't answer them if I don't recognize, so I can't expect people doing it.

WANDA BARFIELD: Yes.

BELINDA PETTIFORD: And I thought there was going to be a way to either do it as an app or a way that people could pull it up on their cell phones.

WANDA BARFIELD: Yeah. So, Belinda, you bring up some really great questions. One of

the things that's sort of unique about PRAMS that might be a little bit different than other surveys is that once you find a mom, they are more than happy to share their story about their pregnancy experience. So, the participation rate is great. It's about 90 percent. Where we have problems is initially finding women perhaps. And as you mentioned, in these times in terms of mail survey, that may be challenging as well as phone at times since we're all being inundated by phone solicitors. So, we are, one, looking at different modes.

So, one is hospital-based mode, which we did in Puerto Rico during Zika and after a hurricane and got, you know, 92 percent response rate for women and over -- don't quote me on this -- it was close to, I think, over 70 percent, close to 80 percent for their male partner because we surveyed men and women about practices in reducing the risk of Zika transmission. So we know that, again, there was a lot of effort and energy and resources that went into that.

[Indiscernible] was an incredible member in Puerto Rico who did that work, who is now part of the PRAMS team.

We also know from other surveys that doing an internet-based survey, although it may have its advantages and conveniences, tends to favor well-educated white women. And so, in terms of the diversity that we see again for internet panel surveys and maybe that's again the digital divide that's driving some of that, we don't see as robust a response rate in those -- in those modes.

Phone survey, we do get a lot more African American and Latino women who respond to the phone survey, again, once we get them, and some of that may be also related to timing. If you can catch a woman earlier, you may get a better response rate.

We're also looking at what we can do to have more representation in terms of making sure that there's a response rate threshold that will reflect representativeness and it may be

going lower on the response threshold. We had a pretty high response threshold compared to other surveys, but we're trying to be a bit more flexible, again, if it does seem that statistically it's representing the population.

BELINDA PETTIFORD: Thank you so much for that update. Thanks.

EDWARD EHLINGER: Great. Well, thank you. Anybody else? Any other questions?

TARA SANDER LEE: Just a quick question.

EDWARD EHLINGER: Go ahead.

TARA SANDER LEE: Thanks, Wanda. Just to -- I know -- I noticed that like one of the established topics is prenatal care. Does that include gathering information about any fetal interventions, whether they be noninvasive or invasive, you know, such as like fetoscopy or fetal surgery? And I know that, you know, that's on the rise and becoming more, you know, becoming more available. I'm just wondering if you're gathering any of that information as well.

WANDA BARFIELD: Yeah. So, fetal surgery, you know, as a neonatologist, fetal surgery is fairly specific and some of the congenital anomalies that are used in the treatment of fetal surgery is still, you know, it's important but still relatively rare. And so, this survey may not be the most ideal way to address those questions. We do know that surveying women on their -- on medical conditions of which they might generally understand but not have a lot of detail may not be as ideal.

What might be ideal is taking that clinical record and then linking it to survey information, you know, doing it the other way around because again, fetal surgery is still fairly rare.

TARA SANDER LEE: Right. Thank you.

EDWARD EHLINGER: Great. Thank you, Dr. Warren, and thank you, Dr. Barfield, for those updates. It's really, really, really helpful.

RECOMMENDATIONS DISCUSSION

EDWARD EHLINGER: All right. Let's

now move on and if you're worried about time, the next three parts of our agenda are really sort of fungible. We can expand or shorten each one of those depending on where we go with our conversation because they're all really focusing on the recommendations that we're working on to get ready for our June meeting to actually finalize and get to the Secretary.

So, what I'm going to do is I'm going to have Vanessa share her screen with the -- with the recommendations -- the draft recommendations that I sent to you last night and again a little edited version earlier this -- today, and we can kind of walk through there to see where -- where we are with our understanding of these recommendations.

The recommendation -- I took the input from the conversations yesterday, the feedback from the people who facilitated those meetings, and from the notes that the notetakers took and had sent to me and then organized it in this format that is part of the document, and then

I arbitrarily moved things around. So, you'll see in the first section that is COVID specific activities, there are some data issues that are there, but I pulled out some other data issues and put them in a separate section related to data. All of that, you know, when we're looking at COVID, it's sort of the starting point, as I say, and I put it just a little bit of introductory information in front of each section. I took out all of the supporting documents -- documentation that were in the recommendations earlier, particularly like the -- in the environmental contributions area. There was a lot of supporting documents, and I took that out to try to just shorten this -- this document. And -- and I start out by saying that -- that we need comprehensive reform. This is a comprehensive issue, maternal and child health, maternal and infant health and well-being is really important, but COVID is a good place to start, so that's why I formatted this as a place to start.

And so, the first three

recommendations are really basically things that we had talked about earlier that we had agreed upon last -- last June. So, I didn't think that, you know, those would have a whole lot of discussion.

Issue numbers 4 and 5 are really data issues that could be put someplace else. And again, they're similar to what we had done before. And then, 8, 9, and 10 are more research issues related to COVID. These are new areas. And then I also in one of the segments in the COVID section, there was a discussion about how we really need to connect with the rural health recommendations and the OMH COVID-19 recommendations. I don't know enough about what they're doing, so I couldn't -- I didn't feel qualified to be able to write that recommendation. So, I'm hoping that somebody who knows more about that will be able to help with that.

But basically, recommendations 7, 8, 9, 10, 11, and 12 are relatively new in our conversation. So, I'm wondering if anybody has

any, you know, any comments to make about those in particular. And your survey, I mean, the earlier ones that we've talked about earlier, we can certainly comment on those, but 7 through 12 are -- - are new in this iteration. And a lot of it is about, you know, new kinds of research focus like particularly 8, 9, and 10 in areas that we really need to look at what's going on with COVID and learn from this experience.

BELINDA PETTIFORD: Ed, this is Belinda. Do we have -- did we cover incarcerated individuals as well?

EDWARD EHLINGER: We do have incarceration in some of the recommendations. I don't -- I don't know if it's in every one of them. I mean, I know it's not in every one, but I think --

BELINDA PETTIFORD: I mean, I think about incarcerated pregnant individuals and some of the challenges they face. I mean, we still have areas where shackling is occurring.

EDWARD EHLINGER: Yeah.

BELINDA PETTIFORD: And so, I'm wondering, do we want to make sure we're including it? I see it under number 1, for example.

PAUL JARRIS: Do you think we might want to just use the term disproportionately impacted or vulnerable and then give a reference to what we mean by it so we don't have to keep repeating it through the paper?

EDWARD EHLINGER: Oh, that would be -- that would be a good idea.

PAUL JARRIS: I also had a question on language. Just scroll down over there.

EDWARD EHLINGER: Okay. Which -- to which number are you --

PAUL JARRIS: To the new -- COVID. Oh, identify documents systemic and social injustice responses. I'm not sure what a social injustice response, if that's a real term. I think it's probably an important area, particularly with some of the Asian violence going on -- violence going on against Asians right now. But it's just more of a wording issue, I think

that's important. And then, I guess, knowing how that is tied to pregnancy and infants is going to be important. But other than racism, it's a tremendous stress level and people are afraid to go out.

EDWARD EHLINGER: Um-hum. Yeah. I think that -- that when that was suggested, the person suggested that was really thinking about some of the -- the racial focus, violence, also, you know, some of the law enforcement interventions, you know, the systemic and different responses. And then the, I think, some of that is -- like eviction. That came out of another one -- eviction. A lot of people are getting that a lot. Well, I guess, a lot of people are getting evicted and what are the impacts of that on birth outcomes.

All right. Any other thoughts on 7 through 12? And does anybody have the expertise to write a recommendation for number 7?

PAUL JARRIS: I can make an inquiry of the team that's working on the language for

rural health item. I don't have any connections to the long-range COVID-19 equity task force.

JEANNE CONRY: I can ask for help if that helps. I don't have the expertise, but I certainly can ask a couple of people for help if that --

EDWARD EHLINGER: Yeah. So, Paul -- Paul Jarris, you said you are working with that group somewhat.

JEANNE CONRY: Okay.

PAUL JARRIS: I have been working with the OMH rural health group. I know who is leading that effort from my point of view with OMH. So, I can reach out to them and ask if they can provide any help.

EDWARD EHLINGER: Okay. This is a good time to raise the point, as when we're done with all of this, I'm going to ask for some volunteers to take some of these things and, you know, finalize them in the next month so that we can get them into final form. So, I'll be asking for some help, and this is one where I would get

some help.

All right. Any other questions on this little section? All right. Then let's go into the workforce and care system transformation recommendations and again, some of these things are ones that we basically developed in our work last year on COVID and are now being put together here, so there's not new. Although the -- we've talked about continued eligibility for Medicaid, the 1115 waivers, we had not talked about the number 3. That's -- that would be a relatively new recommendation because the Rescue Plan would -- is a new issue that we have not seen before. So, any comments on those three?

I see Dr. Barfield has her hand up. I don't know if that's for this or still from the past. All right. All right. With no comments on that, then I had a -- I broke all of the workforce care system transformation recommendation into different parts because it was a large -- a large area. So, the system enhancements, again, the first three are things that we had talked about

before. We had pulled out -- I pulled them out from the COVID response to make them more generalized in terms of, you know, freestanding birth centers, community team approach to all of the pregnancy, labor, delivery, and postpartum care and then again funding through Medicaid. Those are things -- for telehealth -- those are things that we had talked about earlier. So, same thing with number 4. But number 5 is a -- would be a new recommendation.

PAUL JARRIS: Ed, could I go back to 2? This is Paul. We call out funding for telehealth. We don't call out funding for team-based care, and that's a challenge with [indiscernible]. So, how do you compensate, you know, the community providers who are engaged when the payment may to the delivering hospital and delivering physician?

EDWARD EHLINGER: Yeah. All right. So, we could -- are you suggesting that we add that? That when we talk about team-based care adequately resourced or funded?

PAUL JARRIS: Yeah. If we're going to talk about a care team approach, there needs to be a payment that reflects that.

EDWARD EHLINGER: Yeah. So, I guess we would probably have a recommendation that generally would be that health care provider -- there should be a funding mechanism for different approaches to providing care that not just individual provider-focused but team-focused care. I know that, I mean, sort of the accountable care communities are accountable communities for health approach where they look at total cost of care have funding that actually allows for team-based care. That could be a model that could be used. I'm not sure how well it's working in various places, but that could be a recommendation, and we can add that. I'll do that.

BELINDA PETTIFORD: Ed, this is Belinda. Two areas, one under Healthy Start. I'm wondering, do we want to say extend Healthy Start so that every community and/or metropolitan statistical area because I'm not sure we view

Healthy Start as a state program, but it's more of a community program. So, I'm not sure if I would say every state because basically you're looking at it's a community level program. So, I would change it to community, and I do remember at one point there was some data that there were like 300 communities that were eligible.

EDWARD EHLINGER: Yeah, all right.

BELINDA PETTIFORD: So, I would be cautious of saying state.

And then the second one, I'm looking for the language around -- I think we talked yesterday and I think Pat brought it up around diversifying the workforce, and it may come up in another area.

EDWARD EHLINGER: Okay, yeah. We'll get to workforce development here in a second. Let's -- I want to stay on the Healthy Start for a just a second.

BELINDA PETTIFORD: Okay.

EDWARD EHLINGER: That was -- I know you brought that up and from the notes, I know

that you brought that up yesterday. And so, I just pulled this out of the air at midnight last night.

BELINDA PETTIFORD: Understood.

EDWARD EHLINGER: And -- and so, I -- and I remember back in the day when Healthy Start got started, Minnesota didn't qualify because we didn't have a large enough population for Healthy Start, even though we had huge disparities. We just didn't have enough numbers. So, I'm trying -- I'm here to try to say -- trying to get it throughout regardless and based more on disparities than it is on numbers. And that was -- and then I -- I just arbitrarily chose 1.5 as the disparity ratio and I don't -- I think that might even be accurate what is being used now. Dr. Warren, what's the criteria now?

PAUL WARREN: That is my recollection and Healthy Start staff who are on the phone can confirm. But I think when the last competition was done, which was 2019, in the eligibility section, it talked about communities with an

infant mortality rate 1.5 times the national average.

LEE WILSON: That is correct, although we have not fully like boxed ourselves in on that. We do allow other categories or other indicators to be used if the 1.5 either is a datapoint that can't be identified or if there is another way of identifying need.

I do want to point out that this is a decision made at the -- at the program level and not at the legislative level. So, if the committee should choose in the future to want to explore how we are looking at what would be considered a disparity or a need in that area, that is, you know, certainly within your purview.

EDWARD EHLINGER: All right. So, I just used state and metropolitan statistical area thinking that, you know, it could be -- I didn't know -- I didn't realize there were no statewide programs, that they were all more specific community focused.

BELINDA PETTIFORD: yeah, I think if

you're going to keep state, I would say state, community, and/or metropolitan area because you need the community language there and you also -- you want to make sure that rural communities have opportunity as well.

EDWARD EHLINGER: Right.

BELINDA PETTIFORD: And then be looking at high-density area.

LEE WILSON: The legislation does not specifically say you have to award grants to communities. It does include language about community driven. So, a community is a central point of the legislation.

EDWARD EHLINGER: All right, good. So, there's a consensus that we should keep this in with the changes that Belinda suggested, really focusing on state, community, and/or metropolitan statistical areas and we'll leave it at the 1.5 unless I get some feedback from MCHB that that's not aggressive enough. All right.

Then, we had a workforce development area, and I actually had two. Some of that was

more broadly, and again, some of the workforce stuff was in COVID, but I left it there and here's -- and these three, the first one is a new one, and it was sort of what I referenced when Dr. Warren was giving his presentation that resources provided through the American Rescue Plan that are there to expand the community workforce should actually be sort of encouraged to target more of those who work with the maternal and child health population, particularly vulnerable pregnant women and infants, just again trying to do advocacy for the MCH population and all of these resources that are coming to communities. So, that would be a new recommendation. The other two, number 2 and number 3, are things that we had talked about earlier. Any thoughts or questions about that?

STEVEN CALVIN: Yeah. Ed, Steve here. I think we could just reword that a little bit by just saying resources should be provided through ARPA to establish, expand, and sustain a diverse public health workforce. Does that make sense? Yeah. Should be provided through ARPA and

then just instead of the public health, just say sustain a diverse public health workforce.

EDWARD EHLINGER: Okay.

STEVEN CALVIN: And then, just getting rid of -- and then, just make a period and then just the next sentence is the development of a community workforce should particularly dedicate for community health workers.

EDWARD EHLINGER: Right.

STEVEN CALVIN: Just kind of a wording change, but it allows us to put in a focus on a diverse workforce.

EDWARD EHLINGER: Right. Yeah. So, why don't when we get some of the -- if you have specific wording, I would really appreciate you just, you know, doing that and sending me a note with the words.

STEVEN CALVIN: Okay. Okay, sorry. Yeah, I'll do that.

EDWARD EHLINGER: That's fine because I -- I'm not very good at editing on the fly and --

STEVEN CALVIN: We've got some time.

EDWARD EHLINGER: Vanessa is doing the best job she can, but sometimes we may not be able to keep up with that.

STEVEN CALVIN: Okay.

PAUL JARRIS: I think we're taking a very pregnancy-centric and infant-centric [indiscernible.] We're building a life cycle approach. We have prenatal, postpartum, and we also have intrapartum care including family planning that we're not really mentioning here. And it would be important to build all those workforces if we're going to have healthy babies in communities.

I also want to second Pat's note -- comment in the notes.

EDWARD EHLINGER: Let's see. Yeah. So, race-congruent care. That's -- that's a touch issue right now but -- and I -- but I understand the data that point that out. So, we --

PAUL JARRIS: What isn't a difficult issue is the need to have more people -- different

people and other people who are underrepresented as providers in care.

EDWARD EHLINGER: Good. We need a diverse workforce, that's for sure. All right. So, Paul Jarris, any -- if you can see in this document any places where you could add those other providers, particularly those related in the intrapartum, interconception period, you know, if you could make some suggestions on where those -- that might fit and the wording we could use, I'd appreciate that.

All right. Anything else with this section of the workforce development?

PAUL JARRIS: Yeah, I'd actually like to hear from Pat directly. I don't feel like just the word diverse because that means so many things and in this context, it's [inaudible -- audio fades out.]

EDWARD EHLINGER: Well, Pat, do you want to speak up?

BELINDA PETTIFORD: She's putting things in the chat. Pat, are you muted?

PAT LOFTMAN: I am. Are you able to hear me now?

BELINDA PETTIFORD: Yes.

PAT LOFTMAN: Oh, great. Wonderful. Thank you so much. I think there -- if you -- when you speak to women right now, women are actually asking for race-concordant care, and I think the goal is to create a system that is not only safe but reflects the needs of what women want. So, when I -- when I teach students, I always say to them, you know, our goal is to make certain that you have all of the information and skills that you need to provide good care. But if you're not providing also the care that women want, they are not coming in to the system, and our goal should be to get -- to not only get women into the system but keep them in the system, and that only happens when you have a satisfying experience. And women -- if you listen to what women say, a satisfying experience for them, which is -- which is part of respectful care and relationship-building, are providers who look like

them.

EDWARD EHLINGER: Yeah. I know we certainly did that when OB changed from an all-male profession to now mostly female. It was the demands of women to being served by a woman provider, and I suspect the same thing goes on with race-concordant care.

PAT LOFTMAN: Yes. I mean, diversity is a very, very broad term that does not necessarily achieve the goal that I think we want -- where we want to go.

EDWARD EHLINGER: And I -- this -- I'm thinking ahead. I like the idea of what -- having a provider that -- that women have a choice of the provider that they have, that they would choose the provider most comfortable for them and that they have some options in that choice.

PAT LOFTMAN: Yes.

EDWARD EHLINGER: Yeah.

PAT LOFTMAN: I think there's also missing data though to enable this system to be developed adequately to even achieve that because,

as you know, right now if you were to look at the midwifery work, which is the only area which I am competent to speak about, if you look at the midwifery workforce nationally, only about maybe 10 to 13 percent nationally are midwives of color of any kind. So, you're talking about black midwives, Latinx midwives, indigenous midwives, and so, you -- there needs to be data as to what are the limitations and barriers of either getting students in or once they get in, what are the resources necessary to make certain that they are successful in matriculating out. So, I don't know that we have enough data on that and that would be an area of need.

EDWARD EHLINGER: All right. So, the two parts that we need to diversify the workforce and then we need to have a system set up so that women get to choose among a broader array of providers than they may have right now.

PAT LOFTMAN: That's correct.

EDWARD EHLINGER: Okay. That's a good addition. I think I'll try to work on

something that would relate to that. And Pat, also, if you have any suggestions on wording, you know, I always appreciate that. I look for help wherever I can get it.

PAT LOFTMAN: More than happy to.

EDWARD EHLINGER: All right. Great. Anything else in that workforce development? All right. Then, let's go down to workforce development specific to doulas. I figure there will be some discussion here because this is all new stuff. This is a new set of recommendations, and there are seven or nine recommendations in this.

Vanessa, if you could kind of click on in between the page and get rid of the stuff in between. There you go, that would -- double click there, yeah.

All right. So, any -- any questions? So, these were things that -- that basically from my looking at the literature and from talking with a variety of doula providers and what I know about the US Preventive Services Task Force and also my

lack of knowledge about WPSI, which I just -- I'm -- there's a deficiency in my education -- that's where these recommendations came about. Any comments and thoughts that people have?

JEANNE CONRY: I do. So, this is Jeanne Conry.

EDWARD EHLINGER: Yep.

JEANNE CONRY: Okay. So, I guess one of the points that I made is not to detract from doulas per se. I'll have two comments. One is when we're talking about doulas, I think a lot of these recommendations are based on two major sources of information: the Cochrane Review from 2017 and Berghella Summary. And they looked at the service approach. So, what the review was about was doulas, midwives, and I can't remember, I think nurses in extended roles. So, they put together a number of different providers and said that when we have continuous care -- a supportive system of continuous care, that they listed five different outcomes that improved with that. So, rather than focusing on doulas, I think from a

systems approach, it's better to say a level of care or an approach to care and whether that's satisfied by doulas, you know, due to midwifery or whatever approach, it's -- I don't know that we have to prescriptive. And then that's when I said that there's an economic basis that's different than this. But this is -- if we're looking at the type of care, it's what we're getting at.

My second comment, and I'd share the Women's Preventive Services Initiative. It was started in -- proposed initially with Michael Liu when we first began talking about it in 2012, funded in 2016. It was a five-year collaborative to improve the health and well-being of women across their lifespan, and women is defined as adolescence through maturity, and we look at preventive health services, recognizing that we've got very clear recommendations from US Preventive Services Task Force about women's preventive services. We've got our recommendations that come about through vaccine programs. So, those are givens. And then we have -- the Institute of

Medicine had nine recommendations that went into the Affordable Care Act.

So, WPSI was started in 2016, five-year program, it completed this year in 2021, and then we've been renewed for another five years. As I say, it's a collaborative, so ACOG hosts the meetings. I think our leadership there does a phenomenal job of just taking care of all the intricacies of the grant, but it is a collaborative between our nurse practitioners, internists, family physicians, OB/GYNs, and we've got the Institute of Medicine group that sit on this. We review recommendations that come from anybody.

So, certainly, this group could make a recommendation that they would like something evaluated and then we put together all the evidence -- well, we first look and see is it specific for women, you know, is it something that we should be looking at. We have proposals that come through every year. And then, we put together all the evidence. We use the Organ

Evidence-Based Practice Center to pull together the evidence, review that in detail over the course of a year, come up with recommendations, we provide those recommendations to the Health Resources Services Agency, and then they act upon that.

So, my concern in the way this is worded is that we would never go to -- and Lee, you can correct me if I'm wrong -- we would never ask the head of Health and Human Services to tell us what to do. We are the advisors to HRSA of what's the best medical care and what is the appropriate care. So, if you want this to be considered, it would come through WPSI as a recommendation. Any one of us can put that as a recommendation, or the whole group can put it as a recommendation, they would like support -- supportive services in -- well, it would depend on how you phrased it -- during labor and delivery. I heard women say they followed women for much longer time periods. So, this group would decide what they would want evaluated and then make that

as a request to WPSI to put it on their review. But it's not something I would say we would ask Health and Human Services to come to us and tell us what to do.

EDWARD EHLINGER: All right. Good point.

LEE WILSON: So, this is Lee. If I can give an element of this that Jeanne did not cover. So, origins of this were the -- out of the Affordable Care Act was the desire to ensure insurance coverage for preventive services and screenings. So, the recommendations that are made by USPSTF, by ASIP, by the Women's Preventive Services Initiative, Bright Futures, and others must be provided at no cost sharing through private insurance plans. So, and the recommendations are not determined, as Jeanne said, by the Secretary. They are determined by the committee with the acceptance of the Administrator of HRSA.

That being said, I think it sounds to me like the point that Jeanne is making is not to

direct whether it is a particular service provider like doulas -- and if I'm wrong on that, Jeanne, please --

JEANNE CONRY: No, that's exactly it, yeah.

Lee Wilson: And so, I do want to say that the committee is -- although ACOG is a representative organization of the medical establishment -- they're MDs -- the committee is made up of MDs, nurses, midwives, and practitioners from -- from across the board. That being said, I think that there are those who are advocating for specific professions to be called out. That's a decision made by this committee as opposed to where WPSI may choose to go or not go.

JEANNE CONRY: Yeah. I think that's a -- those are great points, and I think I went through some of our decisions or recommendations and the closest to this and I -- let's see, I copied it and I pasted on the document I was sending to Ed -- is around lactation. So, we did not specify a lactation consultant or we did not

specify who would provide lactation services. It's just that services would include a whole host of different recommendations. So, the Women's Preventive Services Initiative recommends comprehensive lactation support services including counseling, education, breastfeeding equipment and supplies during the antenatal, perinatal, and postpartum periods to ensure the successful initiation and maintenance of breastfeeding. So, that is our recommendation.

Then, once we've got recommendations, we also have an implementation half of this group. So, as Lee said, we've got, you know, we've got the five groups that are organizing it, but then we've got a very large multidisciplinary committee that evaluates all the evidence, looks at everything from the National Women's Law Center looking at coverage and everything. Then, we take it to an implementation committee, and the implementation committee says how are we best going to go about implementing the recommendations and what's it going to take.

Now, the implementation committee -- the only part that HRSA is advising and does anything with -- and again, Lee, correct me -- is we make the recommendation. But the implementation is how do we make this so that we are helping women in the very best fashion. What's it going to take from health policy. You know, we've got different insurance groups sitting around the table, we've got women's health groups sitting at the table, all of them to come up with a plan on how do we best implement. And it's unfortunate that nobody on the phone or on the Zoom even knows WPSI because it's a tremendous program that is meant to be like the American Academy of Pediatrics Bright Futures in looking at women's health and determining what care is most appropriate and making sure that women don't have to fight for what their care is. We would hear women could see one provider and be told they'd receive one type of care and a different provider and the recommendations are different. This lays the playing field so matter if you're seeing an

internist, an OB/GYN, nurse practitioner, the advice is the same.

EDWARD EHLINGER: So, I -- I mean, I -- one of the reasons I wanted US -- the United States Preventive Services Task Force and WPSI is because if it gets approved, it gets funded, and that's what I'm finding is that doulas are not getting funded, and that's one of the issues. And I do call out doulas as opposed to putting them into a whole host of others because somebody has to advocate for them. We have not made enough progress, and from the data I've seen, they have a huge impact on disparities. It is one way we can actually develop a workforce in communities of color that could actually then grow into other occupations in the health care field. So, you know, I would argue that doulas are a unique service, that they do, demonstrated from the data I've seen, actually improve birth outcomes and a whole variety of other factors, and they can help reduce disparities, and we need to support them in any way I can find to support them at this point

in time so we can move forward would be a good thing. I don't see a downside to that.

PAUL JARRIS: Ed, this is -- this is Paul, and Jeanne, I do know the Women's Preventive Task Force and to have science and subcommittees and it's a very powerful and helpful group. But, Ed, I think the difference here is this seems more like prescriptive advocacy than advise. It's up to -- unless the doulas have already been reviewed and are category B and for us to recommend they be reviewed as category A doesn't seem like our place nor -- and it's based upon that finding that benefits decisions and licensing and things will be determined. It seems like we're predetermining something and recommending it to a group whose job it is to permit it. So, [inaudible -- audio cut out] I'd like to see everyone have access to a doula. But what we should ask them to do is to evaluate and if we understand what Jeanne is saying, the services and/or profession, and if we want them to look at developing and look at different types of evidence, such as evidence for

decreasing disparities, then we should recommend that. But I don't feel comfortable giving them a predetermined conclusion anymore than I'm comfortable with anybody else interfering with a scientific group.

EDWARD EHLINGER: Right. So, the recommendation in number 2 is really what I wanted to get at is, you know, that we recommend that the preventive services staff evaluate doula services as a preventive service -- I could take out the level A -- but just evaluate, and the same thing should happen with WPSI, should evaluate doula services.

PAUL JARRIS: I'm comfortable with their evaluating and then should their evaluation make it a category A or B, then, [inaudible.] But I think the A and B thing should [inaudible.]

JEANNE CONRY: And if I would say we don't both do the same work. So, if US Preventive Services Task Force takes this on, then we're not going to take it on. We'll let them do it. If US Preventive Services Task Force -- and we talk with

them quite a bit -- if they say that we're evaluating this, we're going to go through the evidence-based practice, we'll adopt whatever their recommendations are.

EDWARD EHLINGER: All right.

JEANNE CONRY: We are a little broader than US Preventive Services Task Force is what we found. There are areas -- let me give, for example, anxiety screening. US Preventive Services recommended -- I can't remember what year -- depression screening. We took on depression screening and accepted that should be a routine part of women's preventive health care and looked at anxiety and said one of our recommendation is we should also screen for anxiety. So, we've expanded with US Preventive Services Task Force does. So, we try not to overlap. We adopt. If US Preventive Services Task Force says this is it, then we're not going to do any more. They've done it; that's it. So, they're complementary in some ways.

EDWARD EHLINGER: Right.

STEVEN CALVIN: Could I also address the issue too? Steve here.

EDWARD EHLINGER: Sure.

STEVEN CALVIN: Yeah. So, I agree with Ed. I understand the concerns, Paul, that you have and Jeanne, you know. But what we're seeing in many states, taking the data that's really pretty much, I mean, I -- I know it's from having been a perinatology skeptic of doula services probably 25 years ago, I would roll my eyes. But seeing what doula service does and we heard yesterday from Merlin and Efua, who are both doulas in New York and gave us their perspective. Many state legislatures have already incorporated doula services, and I think maybe it's a little much of a stretch for us to say all women will be provided access to doula services. But the National Health Law Programs, Doula Medicaid Projects, you know, the advocacy for this is something that HHS through the Secretary can say the evidence is looked at and obviously both your, you know, both the WPSI and, you know, US

Preventive Services Task Force will weigh in on certain things. But I -- I would say the horse is already out of the barn, that doula service is really clearly beneficial.

The continuous labor support in particular in Ed's point about the fact that recruiting and training doula providers, especially in communities of color, is an extremely powerful way to the introduction to care during birth and prenatal and then postpartum care.

So, I think we, you know, I think what we're, you know, what we're doing is we're trying to all, you know, approach this in the right way. But I would say that there will be great disappointment in a number of communities including -- I'd love to hear again from Efua and Merlin what their perspective is because I don't think they want to wait for another year or two or three until someone comes up with, you know, saying it fits in a certain category. Many states, you know, I think Belinda might have

mentioned yesterday, New Jersey has already, especially for Medicaid service, and that's something that can come from CMS.

JEANNE CONRY: So, Steve, let me address that. I've worked with doulas for a decade. I'm not minimizing the work that they do or anything. I'm talking about a process in WPSI. So, WPSI receives a recommendation or a request and we put it through our process. That's a whole methodology that we have based how we approach it, much like US Preventive Services Task Force does. So, all of those other sources are more than welcome to do what they're doing. If you ask us to look at this, we will look at it happily and with the entire team doing it, but we have a process that we will follow. If you go to WPSI, you can see the methodology behind it. We are transparent in how we approach it. We list all of the individuals and all of the groups that work with us and that's the process WPSI will follow.

STEVE CALVIN: Okay.

EDWARD EHLINGER: I think the change

-- the wording is we say look at it, include it, evaluate it, not say --

JEANNE CONRY: Perfect, yeah.

EDWARD EHLINGER: That's the role that you play. That's what I was hoping to get at.

JEANNE CONRY: But I would say it's not HRSA -- it's not helping Human Services. You all should do this -- Ed, you should put that in right now, and I can share the link.

EDWARD EHLINGER: Yeah. That's -- that's where I -- that's why I want to talk with Lee afterwards. He asked the Secretary to do some things but are there things that we can do as a committee that sort of not go through the Secretary that just as a committee that we would say the committee looked at this and really wants you to evaluate it as a preventive service.

PAUL JARRIS: And maybe we could separate it because, you know, if in fact states are covering it as allowable under Medicaid under --

JEANNE CONRY: Exactly.

PAUL JARRIS: -- maybe the ask -- pointing that out and asking the Secretary to promote the incorporation of doulas into Medicaid programs, that's one ask. The second ask is to have two organizations review it.

EDWARD EHLINGER: Yeah.

PAUL JARRIS: And advocate to the organizations.

EDWARD EHLINGER: Right. The other is the essential benefits -- I just put that in as a way to get funding -- if it was an essential benefit, it would get funded. But it would have to be -- if it turns out to be an evaluated program that is -- it should be then considered for essential benefits in the health plans.

All right. So, there's a lot of good input. So, I can -- I can rework this section as we move forward.

All right. Any other comments from anybody related to doulas?

All right. Then, we went to the data

assessment and again, the most -- there are new things. The Maternal and Infant Mortality Review Committee be established in every state, same thing with FIMR, we mandated and funded in every state, and then the others are, I guess, they're all relatively new. So, any comments on these recommendations?

BELINDA PETTIFORD: We've got the number 1 and the number 2. In both of those, we list Infant Mortality Review Committees. But is our focus to get them funded and mandated or is the focus that one be in every state? It seems like 1 and 2 are -- some of the information --

EDWARD EHLINGER: I would think that we want them established and funded in every state.

BELINDA PETTIFORD: Okay.

PAUL JARRIS: Belinda --

BELINDA PETTIFORD: You want --

PAUL JARRIS: Belinda, I want to ask how [inaudible] are maternal and infant mortality used now? I know they are sponsored in different

ways and a lot of structural issues, but is that -- -

BELINDA PETTIFORD: CDC has been really working to try to get -- that's part of their race to enhancing reviews and surveillance to eliminate maternal mortality. They really have -- CDC has really focused on working with pretty much every state possible to establish a Maternal Mortality Review Committee. And what states are charged with is to have some version of legislation because it's hard to establish a committee if you don't -- aren't able to protect it from discovery and requirements to get access to the records. So, I understand if you want -- so, it's the establishment of the committee, but you also want it to include the appropriate legislation, I mean, because the committee established without having access to what they need for the abstractions of cases may be part of the challenge because we've had a Maternal Mortality Review. We've been reviewing deaths in North Carolina since the '40s, but we didn't get a

committee until 2015. So, we were haphazardly reviewing them until we could get the legislation in place. So, you may want to mention that part of it.

EDWARD EHLINGER: All right. If you have some suggestions how to include that in it, that would be helpful.

BELINDA PETTIFORD: I'll send you something.

EDWARD EHLINGER: All right. That would be great.

Other thoughts on any of these four? All right. Then, to the environmental contributions, infant and maternal health. These were basically the same recommendations that were discussed yesterday. I didn't really change anything from what we had -- the group had looked at -- the breakout group. I did take out, like I said, all of the supporting documents and used some of those supporting documents as the introduction to this section. But does anybody have any concerns or questions about these seven

recommendations?

JEANNE CONRY: I just had more wordsmithing because I think it's important to point out that there is a great deal of evidence and research about this. But clinicians and patients aren't aware of it. So, I'm worried about saying that there is limited understanding or limited research and using those. So, I can just send some wordsmithing around those kind of terms.

EDWARD EHLINGER: Okay, good. Oh, the one thing I did add in here, and I didn't add it very well was the whole issue of tobacco, alcohol, marijuana, and other drugs. Those are environmental conditions, but I just sort of plugged them in here and I read it over, and it doesn't read really well. So, we --

JEANNE CONRY: And I would put that -- yeah, I think that's where I would do it too because on the one hand, we've got toxic chemicals and exposures, whether it's climate change or environmental exposures, and we clearly know that

underserved women -- black and Hispanic women -- are most vulnerable. The research there is very, very extensive on personal care products, on pesticides, that they are the most vulnerable. So, calling that out, and you did in the commit and implement stage. And I would say -- what we would say with drugs, alcohol, and tobacco, they are known toxic substances that are currently well recognized for their impact on maternal and newborn health. So, they're kind of -- they're in the same -- I lump all of them as toxic exposures when I'm discussing them with patients. But on the one hand, we recognize more drugs, alcohol, tobacco, and obesity, actually, and then the toxic exposures that we heard about in the presentations.

EDWARD EHLINGER: All right. So, we'll do some wordsmithing on this, Jeanne.

JEANNE CONRY: Okay.

EDWARD EHLINGER: Any other questions or any comments from others? All right.

And then the border health -- migrant

and border health recommendations. Again, these were what Paul Wise had worked on and what the group yesterday -- breakout group worked on, and these were -- I just cut and pasted those from that. So, there are seven recommendations. So, these would all be new.

Paul, any comments? Paul Wise.

PAUL WISE: No, I think this represents our discussion, and I invite all of our group members to speak up if I didn't capture it correctly.

EDWARD EHLINGER: All right. Any other comments on this? Yeah, and this is one that -- an area where I'm hoping we can really come to a consensus in June to get it there because this is obviously a very urgent issue right now. All right.

And then, there was a whole variety of things that have come up over our two years where I have other recommendations that have been discussed but we have not developed any established recommendations. I don't know if

anybody has any interest in elevating any of those issues into, you know, recommendations that we would try to work on and get finalized by June. I mean, there is a broad range of things we know that impact a lot of economic things of tax, policy, earned income tax credits, you know, dependent care tax credits. I didn't develop anything related to these because we already have a fairly comprehensive list of recommendations and this could go on forever. But I -- is there anything that people would like to -- knowing they're all important -- are there any things that you make a case for raising any of these to a higher level for our scrutiny and working?

BELINDA PETTIFORD: Did we close family planning earlier when I think Paul brought it up -- Paul Jarris brought it up?

EDWARD EHLINGER: Yes. I think -- I think that was a good point. I think we do need to work on the family -- the reproductive health area and work that into the -- both into the terms of the team approach, the life course perspective,

and workforce.

TARA SANDER LEE: Can you specifically talk about what you're talking -- the details of family planning? Can you give some specifics of what you're talking about?

PAUL JARRIS: For women to have full access to family planning according to their wishes and values and best medical care.

TARA SANDER LEE: I know, but what details are you talking about? Like what do you consider family planning?

EDWARD EHLINGER: The range of family planning, so reproductive health services that are available to women in this county.

TARA SANDER LEE: Well, I completely reject the plan to put that into these, because if that includes abortion care, why would we include that into something where we're trying to -- is that what you're talking -- abortion care -- access to abortion?

PAUL JARRIS: I think this is a field that defines itself. It's not up to us to define,

include, or exclude if something is there.

TARA SANDER LEE: Well, if it includes -- if you're considering abortion care included in family planning, then I strongly reject putting that in because we're all -- we're a committee that's all about infant mortality. Adding abortion care is going to absolutely determine that you have a dead baby at the end. So, I reject putting any inclusion of family planning if you're talking about abortion care.

JEANNE CONRY: And family planning includes the entire spectrum of women's health resources, which includes access to contraception and abortion. If we don't want to do there, that does not impact infant mortality. It's a separate discussion.

TARA SANDER LEE: There is evidence that it actually does impact subsequent pregnancies.

JEANNE CONRY: No.

TARA SANDER LEE: So, and I agree that's a totally separate discussion.

JEANNE CONRY: Very well-reviewed area. Yeah, very well-reviewed area.

TARA SANDER LEE: I think --

JEANNE CONRY: I agree, we're not going to have that discussion here.

EDWARD EHLINGER: No. I would suggest that we put it in -- the full range of reproductive health services in the next draft that we have and we'll have some further discussion on it down the road because otherwise, it is a long conversation that will be had. But I think that it is important -- it has an impact on maternal health and it has an impact on infant health.

JEANNE CONRY: I absolutely support that in any way. The research, the evidence is clearly there that women should have the full range of reproductive health care and we have the best maternal health outcomes if we do that. So, I agree completely with that statement.

TARA SANDER LEE: I completely reject that and if -- and if -- and if the full access to

reproductive health care goes into these recommendations, I will not accept them, just so you -- just so you know. Just so you know going forward.

EDWARD EHLINGER: I understand that. I understand that. And what we will do is that people can opt out of these recommendations. I don't think that we need to have unanimity in these recommendations. But we need to make sure that at least the majority -- and I hope more than a majority -- support the various recommendations and there's always a chance for a minority report.

LEE WILSON: Ed, this is Lee. I'm going to just mention that the breakout rooms have been set up and there are transcribers in those rooms. So, when you are ready to move those rooms, I wanted to let you know -- move to those rooms, we're ready.

TARA SANDER LEE: I'm just going to leave one more question. Why would we allow access -- how can you possibly consider that providing an abortion and killing the infant is

helping infant mortality? I would like an answer to that.

PAUL JARRIS: I honestly don't think anyone is talking about abortion but you.

TARA SANDER LEE: You just did. You just said that it encompasses the full range of reproductive health care.

PAUL JARRIS: I'm comfortable letting the Secretary decide what that is.

EDWARD EHLINGER: Yeah. All right.

BELINDA PETTIFORD: Ed, on the -- the one around the community health worker one, we -- we have the community health worker one under workforce number 1. So, do you -- it may already be addressed is what I'm trying to let you know.

EDWARD EHLINGER: Okay.

BELINDA PETTIFORD: We've got to expand the public health workforce funding 100,000 public health workers to nearly triple community heath workers. We included health workers with the home visitors, the doulas, navigators earlier on in the document. We just need to put a number

on it.

EDWARD EHLINGER: Okay. All right. So, with that discussion, I would now want to move into our breakout groups for the three breakout groups, and I want you to take the members of those groups to really look at these recommendations to say from the lens that you have.

In the equity -- are we addressing equity in the right way? Are there things that we need to add that would enhance the move towards health equity?

In the data and research group, are the data recommendations appropriate? Do they cover the things that we really need? Particularly in data and research, are there ways that we should maybe collate those into the same area or, you know, separate them out under the topic related to COVID?

And in the quality, care, and access group, really look to see does this get at the systems issues, the quality of care issues, and

the workforce issues that really will advance the health of moms and babies?

So, we're going to go into those breakout rooms just, you know, to look at this from another vantage point to see that we're not missing something or are there things that we should take out, things that we should put in, or things that we should word a little bit differently, and then we'll come back following that and figure out what the next steps are.

So, let's see, it is now 2:00. Let's go for about 45 minutes into those workgroups and come back at quarter to three. Okay? So, choose your breakout group.

And Vincent, I would like to know how many people are in each breakout group -- members are in each breakout group, and I'll go into the one that has the least number.

VINCENT LEVINE: Sure.

[Off the record at 1:59 p.m.]

[On the record at 2:50 p.m.]

EDWARD EHLINGER: All right. Let's

get started here on our last little segment, but I want to start first by having Jeanne make an announcement related to World Patient Safety Day.

JEANNE CONRY: Thanks so much. Yeah, just to let everybody know that World Patient Safety Day was started in 2019 and it was just an announcement and events around patient safety. In 2020, the focus was on COVID and patient safety for health care workers, and in 2021, the theme is maternal and newborn health safety, so really focused around the conditions that improve the health and well-being of infants and moms so that we have a healthy delivery particularly around disparities. It is September 17th and I would love to propose that we ask Health and Human Services to recognize it and be a part of it. It is going to take place at -- the first day of it or the announcements will take place in the United Nations and it is a global event. Every city shows their monuments. So, the National Monument in Rio, the Cristo. They will all be orange in memory -- in recognition of World Safety Day.

So, I've got a PowerPoint I could happily share with folks. They haven't come up with exactly the theme or slogans yet, but it will be around maternal and newborn health.

EDWARD EHLINGER: Good, look forward to more information and we'll see about letting the Secretary know that the US should support this effort.

JEANNE CONRY: Thanks.

NEXT STEPS IN PREPARING RECOMMENDATIONS FOR ADOPTION IN JUNE

EDWARD EHLINGER: All right. So, we're going to -- we have about 25 minutes to sort of talk about next steps related to the recommendations. We'll get a quick report back from the various workgroups to see what kind of input they had and then I wanted to, you know, try to find some way to set some priorities and decide how the next steps should go. And there were -- in the data workgroup, which I attended, Jeanne Conry was there and Paul Wise was there, and we did not have any, you know, major changes related

to the data, but there was a discussion about a large number of recommendations and we may need to -- we should prioritize those and we may need to consolidate some of the recommendations and set some priorities. So, we will do that as we get near the end of this little session here.

And wondering now about the equity workgroup. What kind of discussion did you have?

BELINDA PETTIFORD: We had the discussion. We actually did not make it all the way to the end -- I'm trying to pull my notes up really quick now -- but we made it through most of it, and I was taking notes while we were going along. A couple of areas that we looked at was more general around making sure as we have the data -- as we have the information that we're being consistent throughout the document about, you know, placing the woman first and then the infant because the woman is needed for the infant. So, that's just some minor language.

We wanted to strengthen the language to make sure there was at least one support person

allowed beyond a doula during pregnancy, labor, and delivery, and recovery -- that timeframe. We know that in many of our states and within many of our hospitals that doulas were not allowed to be part of the care team. So, we were just trying to strengthen that language, and I can send it to you.

We also under the area around data and surveillance, we added that we also needed training to increase the comfort level on asking race and ethnicity questions, but also started out by explaining to the individual why you need that information because we are -- we just want to strengthen that area.

As we move forward, we spent some time talking about the CMS language, you know, the language around extending Medicaid coverage for at least 12 months postpartum. I think what we have currently is for women following a Medicaid-financed birth for one year after pregnancy that, you know, the eligibility [inaudible -- audio cut out.] We went down the road with a conversation

well, what about if the individual had a miscarriage or a loss, would they be covered in that 12-month period as well, and so, really trying to think through that language a little bit.

EDWARD EHLINGER: You'll notice -- you'll notice that in the document we have. I tried to get end of pregnancy as opposed to after delivery, which would include, you know, any other -- the end of pregnancy regardless of the reason.

BELINDA PETTIFORD: Good point. Thank you. And then we also wanted to make sure under the area for systems enhancement and financing of care that we talked about broadband internet service, but we added language and a method to access telehealth, then maybe support with a phone or a computer or something of that nature. So, we added some language there that we didn't think it was just broadband, that at times, it was still a broader access issue.

In that same area, we added a sixth bullet under Healthy Start. We put language

around expanding or supporting group prenatal care because we've seen some research on how it impacts birth outcomes as well, especially with communities of color. So, we added in group prenatal care, and I'm working on some language for that.

We made a change on a workforce development under the certified, there's midwives and certified midwives language. We basically changed it to say increase the number of racially and ethnically diverse nurse midwives, midwives, and expand access to them and allow them to practice to the full extent of their master's prepared education, clinical training, and national certification in all states and all facilities.

And that's when we started the conversation around we needed to capture data and surveillance on enrollment and graduation by race and ethnicity. We started talking about nurse midwives, but we feel like it's a broader issue, that it should be captured in all of our health or

Allied health professions. We need to figure out a way to capture that to see if we're even able to diversify our workforce. Are there issues with who is getting enrolled, who is getting admitted, and are there challenges with graduations with certain populations. So, we started that discussion. We did not finalize it.

Then, we added some language around increasing the work and trying to strengthen the work with rural hospitals because we're seeing hospital closures in rural areas, OB unit closures in rural areas, and then we're also concerned about, you know, some of the issues around transportation, especially, you know, whether it's specialty care, whether someone shows up in the emergency room, and they need to quickly get to the next level hospital. I think there was an example, you know, do they have access to a helicopter, fully equipped. So, we did add some language in there around transportation. And then we ran out of time.

EDWARD EHLINGER: You covered a lot.

BELINDA PETTIFORD: And then, well, we did under the last data and assessment, we did separate. We wanted to be clear that for bullet 1 that we meant Maternal Mortality Review and Infant Mortality Review Committees, that it wasn't a combined committee, and that's what we thought it was, but the question came up, so we're just trying to clarify it.

And so, I've got all kinds of little notes and will forward them to you.

EDWARD EHLINGER: Good. Yeah, if you get those, that would really be helpful.

BELINDA PETTIFORD: And I don't know if anyone else -- because we had a good group -- I know Paul was in the group, Cheryl, and Rachel, and I'm losing names, but there were many other people that were in the group, and I mean Paul Jarris.

PAUL JARRIS: The other Paul.

BELINDA PETTIFORD: Otherwise known as the other Paul? Okay.

EDWARD EHLINGER: The sweaty Paul

right now. All right. Steve, how about you in your group?

STEVEN CALVIN: So, our group including Tara, Colleen, Lee Wilson, I think Lily Bastian from ACNM, American College of Nurse Midwives, and Lisa Satterfield from ACOG joined us briefly as well. Belinda covered a lot of the things. I think we have to make sure that we do not forget the challenges of rural healthcare, which certainly impact the racial equity stuff, but just in general, anybody who lives in a rural area is -- has -- relies on a critical access hospital. So, I'll also send these notes too.

We also discussed a bit about the opioid -- the care of opioid-addicted mothers and then subsequently the newborns with neonatal abstinence syndrome and Colleen had some good input about that from a neonatal perspective, and Lee gave us some information just regarding the contact person at HRSA who has a lot of information about that. So, I'll kind of pull that together as well.

We talked a bit as well about, you know, the training of nurse -- neonatal nurse practitioners. I mean, it gets into the weeds but the Dartmouth study on neonatal hospital beds, neonatologists, and the availability about a year and a half ago, it was quite interesting about we have a fairly robust supply of neonatologists and neonatal beds. We don't have as many neonatal nurse practitioners. So, that should also be a focus and HRSA does have its Bureau of Health Workforce Analysis that will access to try to look into that a little bit better.

Belinda also mentioned the group Prenatal Care Option, and it is extremely helpful for -- for mothers from various communities and they're usually not just focused on one community or sometimes led by someone from that community. But I think we have to, you know, make sure that we include that.

We talked a little bit as well about how somewhere in our document, we should just acknowledge that the Affordable Care Act did

provide funding for the Strong Start Study, which was completed and had a really fairly significant outcome that suggested that midwife care and midwife model of care and an option of birth-centered care really did decrease the racial disparities and improved outcomes significantly, and that's -- that just -- we discussed it before, but I think whatever we sent to the Secretary should just be a reminder to take a look at the Strong Start Study, and I think the new pending CMS administrator, she's very, very knowledgeable about that. So, that's -- that's a good thing.

And then finally, I would say as part of access, you know, we do talk about we have all these various services that we want to -- that we would like to have provided to improve care. But somewhere in our recommendations -- maybe not this time, but maybe down the road -- we have to look at the financing and how maternity and newborn care is financed through Medicaid, in particular, because such a large portion of Medicaid or -- yeah, such a large portion of Medicaid maternity

care is provided through managed care organizations, some of which are for profit and some of which are nonprofit, but all of which have -- have the ability to change things, and I think CMS has the ability to push some changes. So, we need to kind of look at how is that financing working and there is in general a movement away from fee-for-service to episode payments, bundled payments that I think will have an impact. So, I think we should just keep that on our radar, and I'll include that in my notes.

And that's about it. Any -- yeah.

EDWARD EHLINGER: All right, thank you. And I would appreciate if, you know, I get the notes on each of those, and then how do we -- how do we move forward with the, you know, coming up with something by June? If you noted that this was -- what I put together last night was eight pages long, lots and lots of recommendations. So, my belief is that we, you know, that many will sort of overwhelm any -- any reader, and I think we -- I don't know if people believe -- if there's

a consensus that we should probably try to consolidate and narrow the scope a little bit and streamline it so that it is not so overwhelming. But that's the sense that I have.

And so, I think there are two approaches to do -- to not lose anything but also narrow it down. One is I believe that we could put together a more comprehensive document that can be part of what MCHB is working on for their -- with the report that they're writing, and we could put all of our recommendations in there with a lot of the supporting area, but then pull out from the set of recommendations a small subset that we could highlight for the Secretary. And I would suggest that I would like to get your input on ways that we should prioritize. But first, before I get to that, is there a sense that we should try to prioritize and limit the scope of the document -- the letter that we send to the Secretary to make it more actionable? Just your thoughts about that.

COLLEEN MALLOY: I would agree. I

think -- sorry, Steve.

STEVEN CALVIN: Go ahead, Colleen.

COLLEEN MALLOY: No, I was just -- I think it's grown so much. We're trying to cover all bases and I think it's lost some of the original focus and so I agree maybe paring it down to things that are more like directly actionable instead of trying to cast a much wider net that might be beyond the scope of our -- the purpose of this committee. So, I think you'd probably have more effect if we narrowed it down a little bit instead of all these extra pieces being added on.

EDWARD EHLINGER: All right, good. Steve.

STEVEN CALVIN: Yeah. I was just going to say I think a letter that kind of summarizes everything because we do have probably four or five major, you know, general areas and then just reference in accompanying document with maybe a little more specificity for recommendations.

EDWARD EHLINGER: Yeah. So, what I

thought I would do is get the input from these -- the -- the workgroups that you've got and then modify the document that I sent around last night, adding things and changing things, and then sending it out to the group with sort of a poll to say how would you prioritize some of these things based on the importance of the -- the issue, you know, and the kind of impact that it could have, whether or not it's actionable, the pragmatic piece of that. What are the -- is there an opportunity now that we would not have, what's, you know, focusing on the opportunity, and then is it something that is unique to SACIM, you know, is it something that no one else would bring forward and that we would recommend. So, you know, sort of develop a poll to get your sense from the committee of how to prioritize, you know, based on the importance of the issue, the opportunity that's there, whether it's actionable, and the unique characteristics of it and then from that, recraft the document or the letter based on that, which would mean also consolidating some of the

things that we could do because my guess is that many of these could be worded in a different way that would narrow it down to, you know, a paragraph as opposed to six paragraphs on the same issue. Does that sound like a reasonable approach?

STEVEN CALVIN: Yeah, it does.

TARA SANDER LEE: Sounds good to me.

EDWARD EHLINGER: All right. And then I would actually -- and I'm -- I'm looking to the workgroup chairs and co-chairs to help actually with some of that prioritization when we get the feedback from folks to come together and say all right, how do we put this together into a workable document and then formatting it from that. So, I really do look forward to working with the workgroup chairs and if anybody else wants to be part of that, that would also, you know, that would be cool.

All right. Anything else on this? So, that's the plan. I'll get feedback from the chairs on the workgroups, redo the document, set

up sort of a scoring sheet or you know issues, and then have you prioritize them from your perspective, sort of, I'm not sure how -- high, medium, and low priority -- and then work with the workgroup chairs to recraft the recommendations and get them out to you as quickly as possible before the June meeting so that you have time to get some feedback on that and then try to finalize the letter in June and the larger document that would support all of the work that we've talked about some time in July or August.

All right. Anything else? Any other comments?

COLLEEN MALLOY: What -- what are your June dates? I didn't see that the date was set.

EDWARD EHLINGER: Vanessa or Lee? I don't have it right in front of me, but I think it was like the 23rd and 24th of June or something like that.

VANESSA LEE: Yeah, that's correct, Ed. It's Vanessa. It's June 23rd and 24th, which

is a Wednesday and Thursday.

COLLEEN MALLOY: So then, how -- just like looking towards the rest of the year because, I mean, that's two months away. So, how -- how often are we charted to have meetings?

EDWARD EHLINGER: We're hoping to have three meetings a year.

COLLEEN MALLOY: June is our third meeting then?

EDWARD EHLINGER: The -- we're going to probably have another meeting in September. Part of the -- the tight timeline here was because the contract with LRG ends at the June. So, they have to get all of their work done by the end of June. So, that squished the timeframe that we've got. And I'll be working with Dr. Warren and Lee and Vanessa on, you know, looking at the schedule for the next year, which I'm hoping some of our meetings will be able to be in person, you know, once -- once we get through the COVID thing. But there will be three. We'll try to equally space throughout the year more or less three times. So,

Lee, any -- any feedback on that?

LEE WILSON: Yeah, just a little bit more. So, Colleen, the concern with the timing, aside from the fact that LRG is ending its -- ending its contract, that's -- the issue there isn't that we couldn't continue to work, it's that we've got -- we've got an organization that has been involved in assisting us all along the way, and we have to recompute the contract. If it's not LRG, then we lose some of that internal corporate knowledge in the development and writing the product. We are, as Ed said, recomputing the contract. We're hoping to have a new contract in place this summer. We are looking at a September date, and we have put in a proposal for a December/January date for the meeting after that. I do believe that for this last -- for this coming year, we had proposed possibly allowing for four meetings with two being in person and two being virtual with a certain degree of flexibility around that because of what's going to happen with the COVID and travel situation.

COLLEEN MALLOY: And I don't know what LRG is.

LEE WILSON: I'm sorry. LRG is just a private company that provides the meeting logistics services, the writing services, transcription, they're the ones who contact you and send out the briefing book and those materials. Sorry.

COLLEEN MALLOY: So, if you had a meeting in June and September and December, that would be five for the year, right?

LEE WILSON: June, September, that would be four for the year.

COLLEEN MALLOY: Because we had one already, and then this is two, and then June is three, and then September is four, and then December is five.

LEE WILSON: I'm sorry. April -- did we have one in January or was it December?

UNIDENTIFIED MALE SPEAKER: Yes. No, we had one in January.

LEE WILSON: The plan is for four

this year. Maybe it would be January then. I don't recall. But what we tried to do is for this year and last year to have four because we had the resources for it. It may get cancelled or pushed, but that's what we're trying to do.

TARA SANDER LEE: Well, and the thing is then, were the dates for June -- because I don't think we were asked as a committee if we were available. Was that -- were we going to discuss those dates at all or is that set in stone?

EDWARD EHLINGER: It was -- we -- I just didn't -- we didn't want to get close to the 4th of July weekend. I did get some feedback from folks who said that they weren't available the last week of June. So, trying to spread it out as close to the end of June as I could make it with those concerns and so decided the 23rd and 24th made the most sense. I didn't poll the whole committee.

TARA SANDER LEE: I think for future, it would really be helpful if we could poll the

whole committee before, I mean, our committee isn't that big. So, if we could just poll members and I understand that we might not be able to get 100 percent, but that would greatly be appreciated.

EDWARD EHLINGER: So, one question I have -- thank you for -- yeah, we can try -- try to do that. This meeting was two half-days as opposed to our January meeting, which was, you know, two full days. How did this work from your standpoint?

UNIDENTIFIED FEMALE SPEAKER: Much better.

EDWARD EHLINGER: Too short? Too long a time? Just right?

JEANNE CONRY: No, this is better.

COLLEEN MALLOY: Much better.

TARA SANDER LEE: Yes, I agree.

EDWARD EHLINGER: Okay.

TARA SANDER LEE: I also appreciated getting the information about a week in advance. So, thank you for doing that. That was helpful.

Like, you know, the recommendations so we had time to read and prepare.

EDWARD EHLINGER: Yeah, okay. All right. So, my guess then, well, I'll be working with the MCHB folks, but it will most likely be two half-days like we did this time in the -- with the June meeting. All right.

Lee, I think it's time for public testimony.

PUBLIC COMMENT

LEE WILSON: Okay. Thank you to all of the individuals who -- well, we put out a notification for public comment. We did receive public comment from one individual. I don't want to thank multiple individuals. It was a comment that was provided in writing and we will make that written comment available for the record and for your review. I believe it was in the -- in the briefing materials and briefing book.

There was no request for verbal comment or for somebody to read any public input or comment, although we have historically in the

past provided an opportunity for individuals who might be on the line to make a comment or a statement if they are interested in doing so.

So, I'm going to over about 30 seconds for somebody -- anyone on the -- on the call or on Zoom to raise their hand. We will have somebody from LRG who is monitoring the hand waves to see whether or not there is anyone who would like to make a public comment, and we will allow an opportunity for that. Please raise your hand if you have an interest in making any comment.

All right. I've given 30 seconds. Absent any raised hands, we will move on with our discussion. Thank you, Ed.

SACIM ORGANIZATIONAL ISSUES

EDWARD EHLINGER: All right. And then you can -- we can turn it right back to you again for the organizational discussion or to Dr. Warren. I'm not sure who is going to walk us through the charter and the members and bylaws and things like that.

UNIDENTIFIED MALE SPEAKER: I think

that is either Lee or Vanessa, right?

LEE WILSON: Yes. Vanessa, could you -- we're jus switching through our list of activities here. Vanessa, can you identify the topics? I'm pulling up my chart here.

VANESSA LEE: Sure. We wanted to provide some updates on the bylaws, the charter renewal, new member nominations, and discuss plans for the June meeting, which I know we've gotten a little bit into.

LEE WILSON: Okay. So, as it relates to the charter and the bylaws, we have sent our bylaws forward as we had discussed previously. They have gone through a review internally within MCHB. We have gotten the input from the advisory group -- from the advisory committee on the proposed charter. It is not unusual in the transition of an administration for them to want to be as engaged as possible in the development and review of -- of those -- the bylaws. And so, we have provided that input to our Office of General Counsel and it is currently with the

Office of the Administrator for review. We are expecting to have the sign-off or approval from the -- from the Office of the Administrator relatively soon and we have given it a secondary review with the intent of trying to insure that any input from the charter or changes to the charter would be parallel to the bylaws. So, from the conversations that we've had with Ed and previous conversations with all of you, we spoke about the proposed changes, and it appears that they will be running relatively in parallel, although I do know that there will be further conversation about recommendations for the charter coming forward.

Our hope is to have the charter submitted shortly following this meeting for review through the process. The charter is something developed by the department and approved by the department. So, we are accepting your input, although that's going to wind its way through the process within the department. The need is for us to have the charter completed and

signed off before the end of the period of operations for the committee to reauthorize the charter. Once it expires, we would have to go through the whole process again. So, we are kind of on a fast track at this point because the administration is having a lot of these come through at the same time that they're doing hiring and transitioning.

So, are there any questions on bylaws and charter?

EDWARD EHLINGER: Or any input on the charter. I don't know if you've, you know, if we're going to make any -- we're -- I guess we don't make the changes. The administration makes the changes in terms of the charter, but they are taking input from us. Any thoughts that people have about things that they would potentially like to see in the charter? The one thing that I'm not sure how we get this in the charter is the importance of the Ex-officio members and are they the right Ex-officio members that are on the committee and how, you know, and how to engage

them and, you know, because a lot of the other issues -- the issues that we deal with, particularly the social and environmental issues, are impacted by other agencies, and is there any way in the charter to sort of highlight the need for that input from our Ex-officio members.

LEE WILSON: I think it's -- I would encourage you to make recommendations to those organizations that you would be interested in having either be Ex-officio members or to be informed of what -- what we are doing. We can take that information and sort through who would be sort of a standing committee member, similar to what CDC is or whether it is something that's more situational and we keep them informed in the process. We do run a lot of other working groups and committees, so we can tap them for whatever the needs are based on what -- what the agenda is for the committee and what the priorities are.

I do want to recognize that we don't want to have a number of Ex-officio members that appears to dwarf in some way the public input that

the advisory group is receiving.

EDWARD EHLINGER: Okay. Other thoughts from other members? Okay. If you do have any thoughts, get them to me or to Lee as quickly as possible because they're going to be acting on this pretty soon because they have to move this forward, and it always takes a while to get through the bureaucracy.

LEE WILSON: So, the next topic that we had for discussion was new member nominations and I wanted to give you an update that the nominees have moved -- have been moved forward and they are going through the review process. We have received good feedback. As I mentioned, I believe, two meetings ago, we received a very robust list of nominees or set of nominees through the public comment mechanism through the Federal Register Notice and we've put together what we feel is a very robust working group that ensures a number of different priorities -- one, broad representation, two, our desire to have sort of an orderly transition of positions on the committee

through staggering of appointments and making sure that that representation is both professional as well as demographic. So, whether that be location around the country, male or female gender focused, and particular interest areas so that we're covering all the fronts. Those -- those categories, some of them, are outlined in the Federal Advisory Committee rules and some of them are the result of feedback that we've received from you, the committee.

So, we are going through that process. We are hoping to have that resolved this summer with the idea that we can bring on the committee members before current terms expire without having to extend people further. It would be a good opportunity to transition with the transition of the charter.

I'd also like to say that the process is a lengthy process and takes about a year under normal circumstances. And so, beginning in June, we will begin the process again of setting forward another set of nominations. Hopefully, we'll get

some input from the department on that so that we can begin the process further. Any questions on the nomination process?

EDWARD EHLINGER: So, how is it decided at the Secretary level? I mean, is there a committee that works on it or is it an individual? You know, how does that work?

LEE WILSON: So, the committee nominees go through the agency, through the -- through MCHB, through HRSA, up to the department. At the department level, there's a good bit of work that goes on. The ethics officials get involved to make sure that there aren't any conflicts of interest at various stages along the way. They look for any vetting concerns that whether or not an individual has been working with a particular organization that might in some way disqualify them. There are people from the Office of Legislation, Public Affairs, and other places to look at priorities that the administration may have set out. That whole vetting process occurs with what is called the Office of the White House

Liaison and then the various staff offices at the department.

Once that is finalized, there is communication between the Office of White House Liaison and the folks at LMB and the Domestic Policy Council to make sure that it is in keeping with general administrative procedures around the Federal Advisory Act and any political priorities that the organization -- that the administration may have. Sort of a Byzantine process, sort of a black box. I'm not sure all of the priorities that go into that decision-making from one administration to the next. We are now at the stage of it being up at the department winding its way through these various steps and we're hoping to hear in the next couple of months.

EDWARD EHLINGER: I bet you the committee members didn't realize how much vetting they had in order to get to where we are.

LEE WILSON: Yes. They -- they are very thoroughly vetted.

EDWARD EHLINGER: Yeah.

LEE WILSON: And we do take in -- and I do want to just say that we're being very deliberate about not saying specifically where something is in the process, (a) because sometimes we don't know, but (b) because individuals are weighing in and some of these are rather private matters for someone's involvement or if they've got a stock fund or something that may disqualify them for various reasons. We don't want to create the situation where someone is identified as having been pulled out of the process because of something maybe of a personal nature.

EDWARD EHLINGER: I fully understand. My understanding is that many of the members of the current SACIM group, our terms end next June, and others that might be another year later or so.

LEE WILSON: Um-hum.

EDWARD EHLINGER: And the thought was to stagger some of the terms so that there's not just a full-fledged, you know, movement away from the committee and a whole new group coming in. How is -- how do you see that happening in terms

of, you know, we are -- right now, we only have like five members or six members on this call and we need, you know, we need a bigger committee, but to get up to twenty-one all at one time would give this huge bolus which would have, you know, again not allow sort of staggered terms. So, how do you plan on doing the staggered term issues?

So, we have presented options forward. We don't get to necessarily make all of these decisions. They may accept what our recommendations are or adjust. One of the things -- we're pursuing a number of different options. One is for individuals who are on the committee and an option is to offer some an extension for a short period of time, not for necessarily a reinstatement for a longer period of time. That would require us giving them a nomination and having them go through the process again. But say, let's say we would take you or Belinda or somebody else and say could we extend them another six months or a year to assist with the staggering process.

We are also looking at making nominations, some individuals for two years, three years, four years, whatever the option is to try to stagger this process going into the future. There will be a couple of years that it may be unavoidable where we have a relatively large number of -- of people rolling off of the committee, and some of that we may not be able to control because there are just some individuals who are done and they don't have the flexibility to extend further.

But our end -- we are pursuing a number of different ways to try to balance the rolling off of individuals and the rolling off of not getting the same type of individuals, all of them rolling off at the same time. We don't want all the pediatricians to leave at the same time and then have a new crop of pediatricians, that sort of thing. So, we are trying to manage it from many levels.

EDWARD EHLINGER: And how is the chair selected? And I've been acting chair during

this whole time and not officially the chair. I'm just the acting chair. How does that position get chosen and verified?

LEE WILSON: So, it is similar to this process. We would make a nomination or a recommendation of an individual to be the chair. Again, it is just usually what we do is we don't recommend one individual. We would give a slate of individuals, whether that's two, three, four individuals that have particular characteristics both from, you know, soft skills, leadership skills, as well as credentials to lead, as well as possibly demographics if those are important or not important to put that forward. Selecting the chair is much less, I would say, or I don't want to say it's less in our hands so much as it is something that is discussed on an individual basis more than a slate of committee members.

EDWARD EHLINGER: Okay, good. Any questions from the group?

COLLEEN MALLOY: I put it in the chat, but are all the terms four years? Is that

right or is it different?

LEE WILSON: So, in general, the terms are four years. We may be proposing -- we have proposed that there would be options for that so that we don't have -- you know, right now, the -- the number of vacancies totals eleven. I'm not saying that we're nominating eleven right now. But we don't want to have a cycle where we have what would be half of the potential membership rolling off in any given year.

EDWARD EHLINGER: Any other comments or questions?

LEE WILSON: Creating policy here guys.

EDWARD EHLINGER: All right. Anything else, Lee?

LEE WILSON: The final thing is just the discussion about the June meeting. The June meeting proposed dates now are June 23rd and 24th. We are proposing a virtual meeting. Those are -- given the difficulties with June, those are relatively solid based on input that we have

received and discussions that we've had. Tara, I hear your -- I heard your point, and we'll make a note of that and ensure that there is more discussion about the options for dates, and I will apologize for any shortcoming on the part of our staff here in that process. That being said, it is not final. If we do need to change, if there is some reason why we absolutely must move it, please let us know. If we want to have that discussion now, that would be terrific. If not, then it has to happen in the next couple days.

TARA SANDER LEE: I appreciate that, Lee. I was wondering if we -- if any -- if we could shift it just to Tuesday and Wednesday, but if not, I understand because there's been a lot of, you know, if that -- if those two days work for a lot of people, then it should be kept. I'm just throwing that out there if there is some flexibility with shifting it to that Tuesday and Wednesday, June 22nd and June 23rd.

LEE WILSON: Okay. I -- I am not at liberty at this point to say one way or the other.

I think what I'd like to know right now is if people have strong, strong feelings one way or the other, please lodge them here -- lodge them now whether either verbally or in the chat, however. We will make note of that. We will go back and explore what the options are. It may stay the way it is. But I do want to -- I do want to say that we have the ability to move it if we must.

EDWARD EHLINGER: All right.

COLLEEN MALLOY: Can I just ask like in the future also, if you know the date to kind of let us know as early as possible because my clinical schedule is made months in advance. So, it just is helpful because then I have to ask people to cover for me and all that.

LEE WILSON: That is totally acceptable and should be expected.

EDWARD EHLINGER: Very reasonable, yes.

All right. Anything else, Lee, that should be --

LEE WILSON: That's all -- that's all

I've got. You've had more time with me than you wanted.

EDWARD EHLINGER: It's always appreciated.

All right. I just want, you know, we've got a little bit of time. I just want to take some time for reflection and I'd like to find out from you, you know, what -- what worked in this meeting, you know, what's one thing that worked and what -- what takeaways do you have from this meeting to get a sense of where -- what we've accomplished and what we haven't accomplished. And actually, I want to start with the MCHB staff, you know, what worked and their takeaways before we hear from the SACIM members. So, Dr. Warren, what -- what were your takeaways from this meeting and what did you see that worked well?

MICHAEL WARREN: So, I think at a high level, the format seemed to be better for keeping folks engaged and having better participation. I feel like you all got to more concrete conclusions as we think about the

recommendations because there are some things that have been sort of brewing over several meetings, and it's time to move some of them along. And so, I think you all got to a good -- good spot there.

I appreciate the way you all and the staff structured the breakouts so it gave people the opportunity to get to multiple sessions yesterday afternoon. That seemed to work well.

And I just want to give a shoutout to the staff. I think -- I don't know if it was mentioned earlier, but we've got a lot of folks deployed to work both on the border and in the COVID response. So, folks are wearing multiple hats right now, and I just wanted to give a shoutout to the staff who are all wearing multiple hats and doing that beautifully.

EDWARD EHLINGER: Thank you, Michael.

Lee, your takeaway.

LEE WILSON: I'll echo Dr. Warren in saying that I think that I was -- I was incredibly pleased with how quickly the committee was able to come together and make some decisions -- even some

of those decisions who disagree or not decide on certain things. But I was not -- I was skeptical that we would get as far as the committee has gotten in the two half-day meetings. I think the half-day approach works very, very well. I think the Zoom format works better than the Adobe Connect format was working before.

Finally, the one thing that I am longing is something is lost in not having the ability to sit and have lunch with folks and have conversations separate from being at the table, and I think we -- we can't lose that in the process because some of the -- some of the real brainwork goes on during those conversations.

EDWARD EHLINGER: Okay. And Vanessa, you're usually behind the scenes. So, what's your takeaway?

VANESSA LEE: Yeah. I'm just relieved the technology worked. But yeah, I think my takeaway was just a deeper appreciation for all of the hard work that goes into your participation and active engagement in these meetings. It was

just as Lee and Dr. Warren said, very clear how much time and just effort you all put into reviewing the recommendations, editing, thinking through what really made sense for HHS. So, I just felt -- I clearly felt that and that was sort of my big takeaway just how much work again all of you did in preparation for the meeting and over the two half-days. So, thank you.

EDWARD EHLINGER: Good. And Dr. Barfield, you're the Ex-officio member who is most engaged in this committee, your takeaways?

WANDA BARFIELD: Yeah. I just think that first of all, I just have to give a lot of credit to the committee members. I've had a chance to observe various committee groups, and I would say your group has been incredibly engaged and actively involved and really thinking through this whole process in a very thoughtful way. So, it's really exciting to see the things that you're focusing on, particularly given this time where the opportunities really are to move the needle on maternal and infant health.

EDWARD EHLINGER: Thank you. All right. Paul Jarris.

PAUL JARRIS: I appreciate all that you put into these meetings in organizing it and a lot of extra work that you can clearly tell thought and then preparation getting this out ahead of time and doing everything. So, I really do appreciate -- appreciate that, and for me, I really value the opportunity to learn from everybody on the committee. So, thank you.

EDWARD EHLINGER: All right. Tara, your takeaway and what worked.

TARA SANDER LEE: My takeaway is I think that the format this time was really -- it allowed us all to engage at a deeper level, and so, I really appreciated that and I know that there's a lot of work that the -- that the subcommittee chairs do in advance of us meeting. So, I just -- I do appreciate that and I do like the way that we had those breakout discussion. I guess my only thought was that we were kind of, you know, we were kind of put into different

breakout sessions, and it might be fun to just kind of at some level be involved in, you know, every aspect that was in the discussion because -- or maybe ask which ones we thought we might want to be in if we felt really passionate about some of them. But overall, I thought it went really well. Thank you.

EDWARD EHLINGER: Colleen.

COLLEEN MALLOY: Yeah, I liked the format. I felt like it was easier to have a discussion. I think it goes back to I do really appreciate the presentations, but it's not as much discussion-based, and I think one thing with presentations is there's always going to be kind of a point that the speaker is trying to make and so, I think it's always helpful when I'm putting a presentation together to say okay, well, there's probably another side, at least one other side. What's the other side, and this is what someone who didn't agree with these opinions might say. So, like sometimes I think like the gatekeeper that allows the presentations really holds a lot

of power because it's kind of like what presentations are allowed to be put forth is the only information that we see and the presentations have so much information and well-studied, and like I think it's great. But there's always, you know, what do they say, three sides to every story? So, sometimes it would be kind of helpful to have -- I think that's why this worked better for me because people could ask more questions than a didactic kind of lecture saying like this is the absolute truth and this is kind of the truth as it is. So, I think a mixture of both. I think last time was a lot more presentation-based, and I think maybe a mixture or hybrid of the two works well.

I still don't exactly know like how -- I don't know the format of like how the presentations are chosen because I know like some people have tried to get speakers in and nothing happened and then -- so, I don't know if that could be like a little bit more transparent on how you select what people are giving the

presentations because that kind of flavors the whole meeting. That would just be my advice for the future.

EDWARD EHLINGER: Thank you. Steve.

STEVEN CALVIN: I liked the shorter meeting. I mean, the other times, it would take almost a few hours and I know many of you worked harder on it than I have, but eight hours is overwhelming. So, I like the half-day and I appreciate the work, Ed, you've put in. I also appreciate the work that all the career people at MCHB and Wanda have put into. I learn a lot just by being here.

EDWARD EHLINGER: Good. Jeanne.

JEANNE CONRY: I want to echo was Steve said because I think the work from all of the career leadership here makes all the difference in the world for us being able to go forward and get some insight and understanding and then, Ed, the fact that you take all the notes at the end of the day, no matter how late it is, and reformat it and get it back to us is greatly

appreciated. So, thank you for your leadership for all of us.

EDWARD EHLINGER: Well, you know, what works for me is the fact that we've got some really talented and experienced people on this committee. Just the expertise that you bring to this and the commitment and the willingness to work with us is really, really remarkable. So, I appreciate that.

And I really liked the fact that this meeting wasn't about presentations. I think we need to have more of the time when we just talk and debate and discuss. Presentations are important, but, you know, we had those for several meetings, and we never really had a chance to get into depth in some of the conversation. And the fact that you all participated and that we set it up in terms of a way that we had a couple of different breakouts, three breakouts where you had a chance to talk, I think that works because I liked hearing your voice.

Just like I do like the voices of the

community at the beginning of our meeting and the two doulas that presented on Monday morning or Monday afternoon, I thought, were really powerful. We did have a video, which I thought was very powerful. But I'd love to have more voices like that and actually build in sort of a strategy about if we're going to be talking about some subject during the meeting, have some voices from the community that reflect the stories around that topic and I would hope that it would come not just from the people that I know or the connections that I have, but come from the connections that all of you have.

And I do like -- what I think works is that we -- we did have a sense of urgency. I mean, we have an opportunity now to make some recommendations to a brand new administration that has a lot of resources coming down the pike that there are a lot of things that are, you know, front and center in terms of maternal and infant health and disparities that -- that we can actually have an impact on, and I got a sense that

people accept that urgency and really do want to come up with something that's doable and practical and not just wait for, you know, three years to put together a comprehensive report but get something out. So, I'm hoping that we can stay engaged over the next couple of months, get something that we can finalize in June, and have an impact on the health of moms and babies, you know, moving forward. And as I say that moms and babies, I laughed inside when Belinda said, you know, we should put mothers in pregnant women and infants. As an English major, does that mean pregnant women and pregnant infants? Pregnant infants? So, I always say infants and pregnant women so there's no -- there's no confusion. But, like I say, I have my own little internal quirkiness.

But anyway, given all that, thank you very much for your input. I look forward to your continued input, your continued partnership in trying to make a difference, and I will be getting back to you as quickly as I can after I get all

the information from the workgroups, do a little poll, then reconfigure with the chairs of the workgroups and get something back to you again. And I hope we get it far enough in advance so that you can have -- we can maybe even have some E-mail conversations prior to our meeting in June.

So, with that, I say the meeting is adjourned.

[Whereupon the meeting was adjourned.]

[Off the record at 3:48 p.m.]

REPORTER CERTIFICATE

I, Gary Euell, Court Reporter and the officer before whom the foregoing portion of the proceedings was taken, hereby certify that the foregoing transcript is a true and accurate record of the proceedings; that the said proceedings were taken electronically by me and transcribed.

I further certify that I am not kin to any of the parties to this proceeding; nor am I directly or indirectly invested in the outcome of this proceedings, and I am not in the employ of any of the parties involved in it.

IN WITNESS WHEREOF, I have hereunto set my hand, this 3rd day of May, 2021.

/S/
_____
GARY EUELL
Notary Public